Westminster Public Schools
1/1/2020 Medical Plan Benefit Summary

The table below summarizes the key features of the medical plans. The coinsurance amounts listed reflect the amount the plan pays. Please refer to the official plan document for additional information on coverage and exclusions.

Summary of Covered Benefits	Kaiser DHMO 500	Kaiser 230 Low HMO	Kaiser 220 High HMO	Kaiser ACDC Coinsurance POS		
	In-Network Only	In-Network Only	In-Network Only	Plan Provider	Participating Provider	Non-Participating Provider
Annual Deductible						
Individual	$500	None	None	$1,000	$2,000	$3,500
Family	$1,500	None	None	$2,000	$4,000	$10,500
Out-of-pocket Maximum	Includes ded and all copays	Includes all copays	Includes all copays		Includes ded and all copays	
Individual	$2,500	$6,000	$2,000	$3,000	$4,000	$8,000
Family	$5,000	$12,000	$4,500	$6,000	$8,000	$24,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	
Coinsurance	90%	N/A	N/A	90%	80%	60%
Physician Services						
Primary Care Physician	$30 copay*	$30 copay	$20 copay	$35 copay*	$50 copay*	Ded, 60%
Specialist	$45 copay*	$50 copay	$30 copay	$50 copay*	$65 copay*	Ded, 60%
Preventive Care						
Child/Adult	100% covered	100% covered	100% covered	100% covered	100% covered	$70 copay
Urgent Care (Kaiser after hours clinic)						
After-Hours Care	$45 copay*	$75 copay	$50 copay		$50 copay*	
Hospital Services						
Inpatient	Ded, 90%	$750 copay	$500 copay	Ded, 90%	Ded, 80%	Ded, 60%
Outpatient Surgery	Ded, 90%	$350 copay	$200 copay	Ded, 90%	Ded, 80%	Ded, 60%
Emergency Room	Ded, 90%	$300 copay	$250 copay		Ded, 90%	
Lab/X-Ray						
Diagnostic Lab	100% covered	100% covered	100% covered	100% covered	Ded, 80%	Ded, 60%
Diagnostic X-Ray	Ded, 90%	100% covered	100% covered	Ded, 90%	Ded, 80%	Ded, 60%
High Tech (MRI, CT scans)	Ded, 90%	$150 copay per test	$100 copay per test	Ded, 90%	Ded, 80%	Ded, 60%
Prescriptions						
Generic	$15 copay	$20 copay	$15 copay	$25 copay	$30 copay	50%
Brand	$40 copay	$40 copay	$30 copay	$40 copay	$45 copay	50%
Non-Preferred Brand	Not covered	Not covered	Not covered	50%	50%	50%
Specialty	20% up to $250	20% up to $250	20% up to $250	20% up to $250	20% up to $250	50%
Mail Order	2x retail copay	2x retail copay	2x retail copay	2x retail copay	2x retail copay	N/A
Therapies						
Therapies Limits	20 visits per therapy per year	20 visits per therapy per year	20 visits per therapy per year		20 visits per therapy per year	
PT,OT, & Speech Therapy	$30 copay*	$30 copay	$20 copay	$35 copay*	$50 copay*	Ded, 60%
Chiropractic Limits	**20 visits per year**	**20 visits per year**	**20 visits per year**	20 visits per year		Not covered
Chiropractic Care	**$30 copay**	**$30 copay**	**$20 copay**	$35 copay	$35 copay	Not covered
Vision						
Refractive Exam	$30 copay*	$30 copay	$20 copay	$35 copay*	Not covered	Not covered
Hardware	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

NOTE: This summary is for illustrative purposes only. Any discrepancies between this summary and the plan documents, the plan documents will prevail.

*Coinsurance for covered services received during a visit