Keenan

Chabot-Las Positas Community College District

Summary of Kaiser Plans	Current	Current
Effective Date	7/1/2026	7/1/2026
Carrier Name	Kaiser	Kaiser
Plan Name	HMO - $5 copay plan (High)	HMO - $20 copay plan (Low)
Eligible Class	Eligible Employees	Eligible Employees
	Schedule of Benefits	Schedule of Benefits
General Plan Information		
Annual Deductible/Individual	None	None
Annual Deductible/Family	None	None
Coinsurance	100%	100%
Office Visit/Exam	$5 copay	$20 copay
Outpatient Specialist Visit	$5 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$1,500
Annual Out-of-Pocket Limit/Family	$3,000	$3,000
Lifetime Plan Maximum	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes
Preventive Services		
Well-Child Care	100%	100%
Immunizations	100%	100%
Well Woman Exams	100%	100%
Mammograms	100%	100%
Adult Periodic Exams with Preventive Tests	100%	100%
Diagnostic X-Ray and Lab Tests	100%	100%
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%
Inpatient Hospital Services		
Inpatient Hospitalization	100%	$500 copay per admit
Pre-Authorization of Services Required	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	$500 copay per admit
Surgical Services		
Outpatient Facility Charge	$5 copay	$20 copay
Emergency Services		
Emergency Room	$5 copay waived if admitted	$100 copay waived if admitted
Ambulance		
Air	100%	100%
Ground	100%	100%
Urgent Care		
Urgent Care Facility	$5 copay	$20 copay
Mental Health Benefits		
Inpatient Care	100%	$500 per admit
Outpatient Care	$5 copay/individual; $2 copay/group therapy visit	$20 copay/individual; $10 copay/group therapy visit
Substance Abuse		
Inpatient Hospitalization	100%	$500 copay per admit
Outpatient Services	$5 copay/individual; $2 copay/group therapy visit	$20 copay/individual; $5 copay/group therapy visit
Prescription Drug Benefits		
Generic	$5 copay	$10 copay
Brand (Formulary/Preferred)	$15 copay	$20 copay
Number of Days Supply	100 days	30 days
Mail Order		
Generic	$5 copay	$20 copay
Brand (Formulary/Preferred)	$15 copay	$40 copay
Number of Days Supply for Mail Order	100 days	100 days
Other Services and Supplies		
Durable Medical Equipment & Prosthetic Devices	100%	100%
Home Health Care	100% (up to 100 visits/accumulation period)	100% (up to 100 visits/accumulation period)
Skilled Nursing or Extended Care Facility	100% (up to 100 days/benefit period)	100% (up to 100 days/benefit period)
Hospice Care	100%	100%
Chiropractic Services	Not Covered	Not Covered
Acupuncture	Not covered. Covered only when deemed medically necessary. Must be referred by Plan Physician.	Not covered. Covered only when deemed medically necessary. Must be referred by Plan Physician.
Hearing		
Screening	100%	100%
Aid(s)	Not covered	Not covered
Infertility		
Diagnosis	$5 copay	$20 copay
Treatment	See plan certificate	See plan certificate
Outpatient Rehabilitative Therapy Services		
Physical	$5 copay	$20 copay
Occupational	$5 copay	$20 copay
Speech	$5 copay	$20 copay

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.