2021-22 Medical Benefits & Rate Comparisons

This Summary is intended for Benefit Eligible Employees (regular status with an FTE of 0.50 or greater)

	Kaiser Permanente		Kaiser Permanente	
Plan Name	PPO Deductible		PPO HDHP HSA	
Annual Deductible	**Kaiser Network**	**First Choice Network**	**Kaiser Network**	**First Choice Network**
Individual	$750	$1,500	$4,000	$4,000
Family	$750/person; $2,250 max	$1,500/person; $4,500 max	$4,000/person; $8,000 max	$4,000/person; $8,000 max
Annual Out-of-Pocket Maximum				
Individual	$2,250	$4,500	$4,000	$4,000
Family	$2,250/person; $4,500 max	$4,500/person; $9,000 max	$4,000/person; $8,000 max	$4,000/person; $8,000 max
Professional Services				
Primary Care Office Visit	$25	$25	0% after ded	0% after ded
Specialist Office Visit	$35	$35	0% after ded	0% after ded
Urgent Care	$45	$45	0% after ded	0% after ded
Alternative Care	$15, $1500 Max	$15, $1500 Max	$15 after ded, $1500 Max	$15 after ded, $1500 Max
Preventive Care Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Diagnostic Lab & X-Ray Services	$25	$25	0% after ded	0% after ded
Advanced Imaging (CT, MRI, etc.)	$100	30% after ded	0% after ded	0% after ded
Hospital & ER Services				
Inpatient Services	20% after ded	30% after ded	0% after ded	0% after ded
Emergency Room	$200 after ded	$200 after ded	0% after ded	0% after ded
Ambulance (Ground)	20% after ded	20% after ded	0% after ded	0% after ded
Other Services				
Pediatric Dental (to age 19)	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**
Pediatric Vision Exam (to age 19)	$25 PCY	$25 PCY	0% after ded PCY	0% after ded PCY
Adult Vision Exam	$25 PCY	$25 PCY	0% after ded PCY	0% after ded PCY
Prescription Drug Coverage				
Prescription Deductible	**None**	**None**	**Included in Medical Ded**	**Included in Medical Ded**
Out-of-Pocket Maximum	Included in Medical Max	Included in Medical Max	Included in Medical Max	Included in Medical Max
30-day Supply	$10/$20/$40	$15/$30/$50	**0% after ded**	**0% after ded**
Specialty Drugs	$10/$20/$40	$15/$30/$50	**0% after ded**	**0% after ded**
Premium/Enrollment	**Monthly Rates**		**Monthly Rates**	
Employee Only	$799.76		$690.54	
Employee & Spouse	$1,607.52		$1,387.99	
Employee & Child(ren)	$1,431.57		$1,236.07	
Employee & Family	$2,239.33		$1,933.52	

	Kaiser HMO	Kaiser HMO Deductible
Plan Name	HMO $0d	HMO $1500d
Annual Deductible	**In-Plan Only**	**In-Plan Only**
Individual	None	$1,500
Family	None	$1,500/person; $4,500 max
Annual Out-of-Pocket Maximum		
Individual	$2,500	$5,350
Family	$2,500/person; $5,000 max	$5,350/person; $10,700 max
Professional Services		
Primary Care Office Visit	$25	$25
Specialist Office Visit	$35	$35
Urgent Care	$45	$45
Alternative Care	$15, $1500 Max	$15, $1500 Max
Preventive Care Services	Covered in Full	Covered in Full
Diagnostic Lab & X-Ray Services	$25	$25
Advanced Imaging (CT, MRI, etc.)	$50	$100
Hospital & ER Services		
Inpatient Services	$200/day; $1000 Max	20% after ded
Emergency Room	$200	20% after ded
Ambulance (Ground)	$100	20% after ded
Other Services		
Pediatric Dental (to age 19)	**Not Covered**	**Not Covered**
Pediatric Vision Exam (to age 19)	$25 PCY	$25 PCY
Adult Vision Exam	$25 PCY	$25 PCY
Prescription Drug Coverage		
Prescription Deductible	**None**	**None**
Out-of-Pocket Maximum	Included in Medical Max	Included in Medical Max
30-day Supply	$15/$30/$50	$15/$30/$50
Specialty Drugs	$15/$30/$50	$15/$30/$50
Premium/Enrollment	**Monthly Rates**	**Monthly Rates**
Employee Only	$681.37	$548.13
Employee & Spouse	$1,369.55	$1,101.74
Employee & Child(ren)	$1,219.65	$981.15
Employee & Family	$1,907.83	$1,534.76

First Choice Network Link: http://www.kp.org/addedchoice

IMPORTANT INFORMATION ABOUT OUT OF NETWORK (non-Kaiser/non-First Choice providers) COVERAGE		
PPO Plan	**HDHP (HSA) Plan**	**HMO Plan**
1) Deductible = $2,250/$6,750 2) Out-Of-Pocket Maximum = $6,000/$12,000 3) Cost share for services = 40% (after deductible)	1) Deductible = $6,900/$13,800 2) Out-Of-Pocket Maximum = $6,900/$13,800 3) Cost share for services = 0% (after deductible)	Out-Of-Network coverage is limited to urgent/emergent care

Employer Monthly Contribution*	
Employee Only	$755
Employee & Spouse	$945
Employee & Children	$875
Employee & Family	$1,350
Waiver Credit	$100

*Full-time (0.83 or greater) receive one of the amounts listed above. FTE between 0.50 and 0.82 benefit is prorated (ex. 0.50 FTE receives $377.50 for employee only coverage)

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Rates are good for an April 1, 2021 effective date. Benefits shown represent coverage with preferred providers. This comparison and reference to out-of-network benefits is a brief summary and its accuracy is not guaranteed. For additional benefit details or more information about Out-of-Network Coverage, visit www.linfielduniversitybenefits.com.

2021-22 Dental, Vision, Life and Disability Benefits & Rate Comparison

This Summary is intended for Benefit Eligible Employees (regular status with an FTE of 0.50 or greater)

	Willamette Dental	Principal Dental
Benefits	**In-Plan Only**	
Annual Deductible	None	$50/person; $150 max
Annual Maximum	None	$1,500/person
Office Visit Copay	$20/Visit	None
Claims Paid Percentile	N/A	99th
Waiting Period	None	None
Preventive Services		
Member Responsibility	**$20**	**Covered in Full after ded**
Benefits Apply Toward Max	**N/A**	**Yes**
Cleanings/Exams	*	*
Bitewings	*	*
Sealants	*	*
Space Maintainers	*	*
Basic Services		
Member Responsibility	**$10 - $200**	**20% after ded**
Fillings	*	*
Endo- & Periodontics	*	*
Oral Surgery	*	*
General Anesthesia	Nitrous Oxide	*
Major Services		
Member Responsibility	**$275+**	**50% after ded**
Inlays/Onlays	*	*
Bridges/Crowns/Dentures	*	*
Implants	$1500 Max Benefit, 1/yr	Not Covered
Orthodontia - Adult & Child	$1500 Copay	50%, $1000 Max
Premium/Enrollment	**Monthly Rates**	**Monthly Rates**
Employee Only	$39.10	$46.24
Employee & Spouse	$78.20	$88.94
Employee & Child(ren)	$87.95	$107.06
Employee & Family	$117.30	$157.05

	VSP Vision
Benefits	
Vision Exam	$20
Exam Frequency	Every 12 months
Vision Lenses	$20
Lenses Frequency	Every 12 months
Vision Frames	$130 Allowance after $20
Frames Frequency	Every 24 Months
Contact Lens (in Lieu of Glasses)	$130 Allowance after $20
Frequency	Every 12 Months
Premium/Enrollment	**Monthly Rates**
Employee Only	$5.58
Employee + Spouse	$8.92
Employee & Children	$9.11
Employee & Family	$14.69

	Principal
Life and AD&D Insurance	
Employee Benefit	$50,000
Short-Term Disability	
Employee Benefit	66.67% to $1500 Max/wk 30 days Elim Pd; 22 Wk Benefit Pd
Long-Term Disability	
Employee Benefit	66.67% to $6000 Max/mo 180 days Elim Pd
Premium	Paid by Linfield

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