



# BENEFITS AT A GLANCE

01/01/2023 - 12/31/2023

Features	Kaiser Permanente – Bronze 6250 HDHP HSA Qualified Plan	Kaiser Permanente – Silver 4000 Copay Plan	Kaiser Permanente – Gold 1500 Copay Plan
<b>Calendar Year Deductible</b> <i>(individual/family)</i>	\$6,250 Individual \$12,500 Family	\$4,000 Individual \$8,000 Family	\$1,500 Individual \$3,000 Family
<b>Out-of-Pocket Max</b> <i>(individual/family)</i>	\$7,000 Individual \$14,000 Family	\$9,100 Individual \$18,200 Family	\$7,500 Individual \$15,000 Family
<b>Coinsurance</b>	You pay 35%	You pay 35%	You pay 20%
<b>Office Visit Copay</b>	\$50 PCP / \$70 Specialist after deductible	\$50 PCP / \$85 Specialist	\$25 PCP / \$65 Specialist
<b>Preventive Care*</b>	Covered at 100%	Covered at 100%	Covered at 100%
<b>Virtual Visits</b> <i>(designated virtual care network)</i>	Covered at 100% after deductible	Covered at 100%	Covered at 100%
<b>Mental Health &amp; Substance Abuse</b>	Outpatient: \$50 after deductible Inpatient: 35% after deductible	Outpatient: \$50 copay Inpatient: 35% after deductible	Outpatient: \$25 copay Inpatient: 20% after deductible
<b>Inpatient Hospitalization</b>	You pay 35% after deductible	You pay 35% after deductible	You pay 20% after deductible
<b>Outpatient Surgery – In Hospital Ambulatory Surgical Center</b>	You pay 35% after deductible You pay 25% after deductible	You pay 35% after deductible You pay 25% after deductible	You pay 20% after deductible You pay 10% after deductible
<b>Lab &amp; X-Ray</b>	You pay 35% after deductible	You pay 35% after deductible	You pay 20% after deductible
<b>Major Imaging/MRI/CT/PET</b>	You pay 35% after deductible	You pay 35% after deductible	You pay 20% after deductible
<b>Emergency Room</b>	You pay 35% after deductible	You pay 35% after deductible	You pay 20% after deductible
<b>Urgent Care</b>	You pay 35% after deductible	\$100 copay	\$75 copay
<b>Rx Copays</b> <b>Retail (30 day supply)</b> <b>Mail Order (90 day supply)</b>	You pay 35% after deductible	\$15 / \$75 / \$450 / \$500 \$30 / \$150 / \$900	\$15 / \$80 / \$400 / \$500 \$30 / \$160 / \$800
<b>Out-of-Network Benefits</b>	NO Coverage	NO Coverage	NO Coverage
<b>Employee Cost per pay period:</b>			
Employee Only	\$0.00	\$0.00	\$0.00
Employee + Spouse	\$98.54	\$109.32	\$126.16
Employee + Child(ren)	\$83.76	\$92.92	\$107.23
Employee + Family	\$182.31	\$202.24	\$233.39

\*Examples of preventive care services include routine physical exam, well baby and child care, immunizations, bone density tests, cholesterol screenings, mammograms, pap smears/pelvic exams, preventive colonoscopies, prostate test, lab procedures, screenings for HIV, HPV, and domestic violence, breastfeeding supplies, contraceptive drugs, devices, and sterilization, smoking cessation, etc.

To view a list of medical providers you can visit [www.kp.org](http://www.kp.org)

## Principal Dental – Dental Insurance

Plan Name	Base Plan	Buy Up Plan
<b>Deductible</b> ( <i>individual/family</i> )	\$50 / \$150	\$50 / \$150
<b>Annual Maximum Benefit</b>	\$1,000 per person	\$1,500 per person
<b>Preventive Services</b> ( <i>exam, cleanings, x-rays</i> )	Covered at 100%	Covered at 100%
<b>Basic</b> ( <i>fillings, extractions, oral surgery, periodontics, endodontics</i> )	Covered at 80% after deductible	Covered at 80% after deductible
<b>Major</b> ( <i>crowns, bridges, implants</i> )	Covered at 50% after deductible	Covered at 50% after deductible
<b>Orthodontia</b> ( <i>children up to age 19</i> )	Not Covered	Lifetime maximum of \$1,500 (per child)
<b>Coverage</b>	<b>Per Pay Check Premium</b>	<b>Per Pay Check Premium</b>
Employee Only	\$0.00	\$8.29
Employee + Spouse	\$11.82	\$26.49
Employee + Child/ren	\$19.89	\$48.38
Family	\$34.65	\$71.35

## Principal (VSP Choice Network) – Vision Insurance

Plan Name	In-Network Benefits
<b>Eye Exam</b> ( <i>every 12 months</i> ) <b>Prescription Glasses Copay</b>	\$10 copay \$25 copay
<b>Materials</b>	Included in Glasses copay
• <b>Lenses</b> ( <i>every 12 months</i> )	\$150 frame allowance
• <b>Frames</b> ( <i>every 24 months</i> )	\$150 contacts allowance
• <b>Contacts in lieu of lenses</b> ( <i>every 12 months</i> )	
<b>Coverage</b>	<b>Per Pay Check Premium</b>
Employee Only	\$4.62
Employee + Spouse	\$8.06
Employee + Child/ren	\$9.80
Family	\$14.27

## Principal - Life Insurance

### Basic Life and Accidental Death and Dismemberment (AD&D)

<b>Basic Life Benefit</b>	\$20,000
<b>AD&amp;D Benefit</b>	\$20,000
<b>Age Reduction</b>	Benefit reduces to 65% at age 65; 50% at age 70

## Principal - Disability Insurance

### Short Term Disability

<b>Weekly Benefit</b>	60% of weekly salary to a max of \$2,000 per week
<b>Benefits Begin</b>	8 <sup>th</sup> day for accident or illness
<b>Benefit Duration</b>	12 weeks

### Long Term Disability

<b>Monthly Benefit</b>	60% of monthly salary to a max of \$9,000
<b>Benefit Begins</b>	90 days
<b>Benefit Duration</b>	24 Months (Own Occupation) Social Security Retirement Age (Total Disability)

## Voluntary Benefits – Principal

Ancillary benefits available for employee and dependents. Refer to the Online Enrollment Portal for additional information and costs.

- Accident Coverage
- Critical Illness
- Voluntary Life

## LegalShield & ID Shield

Additional coverage through LegalShield & IDShield is available. Refer to the Online Enrollment Portal for additional information and costs.

### Need help with your benefits? Have a question?

Our Benefit Advocate at Intrepid is standing by to help you with basic or complex benefit needs such as claim questions, billing issues, policy information, ID card requests and more!

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