Keenan®

Moraga School District

2026 Kaiser HMO Plans/Rates

Carrier	Kaiser Permanente		
Plan Name	**$5 copay/ $250 Admit**	**$15 copay $1500/$3000**	**DHMO $20 copay/$500 Ded**
General Plan Information			
Annual Deductible/Individual	$0	$0	$500
Annual Deductible/Family	$0	$0	$1,000
Coinsurance	100%	100%	90%
PCP/Specialist Office Visit/Exam	$5 copay	$15 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$1,500	$3,000
Annual Out-of-Pocket Limit/Family	$3,000	$3,000	$6,000
Primary Care Physician Election Required	Yes	Yes	Yes
Outpatient Services			
Preventive Services			
Well-Child Care	$0 copay	$0 copay	$0 copay
Immunizations	$0 copay	$0 copay	$0 copay
Well Woman/Mammogram Exams	$0 copay	$0 copay	$0 copay
Hearing/Vision Exams	$0 copay	$0 copay	$0 copay
Adult Periodic Exams with Preventive Tests	$0 copay	$0 copay	$0 copay
X-Ray/ Lab Tests - Non-Preventive	$0 copay	$0 copay	$10 copay
Outpatient Rehabilitative Therapy	$5 copay	$15 copay	$20 copay
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal Care)	$0 copay	$0 copay	$0 copay
Inpatient Hospital Services			
Inpatient Care (Facility & Physician Fees)	$250 copay per admission	$250 copay per admission	10% after deductible
Surgical Services			
Outpatient Facility Charge	$5 copay per procedure	$15 copay per procedure	10% after deductible
Emergency Services			
Emergency Room (Waived if admitted)	$35 copay	$35 copay	10% after deductible
Ambulance - Ground	100%	100%	$150 per trip
Urgent Care			
Urgent Care Facility	$250 copay per admission	$250 copay per admission	10% after deductible
Mental Health/Substance Abuse Benefits			
Inpatient Care (Facility & Physician Fees)	$5 Copay Individual; $2 copay Group	$15 Copay Individual; $7 Copay Group	$20 copay Individual; $10 copay Group
Outpatient Care	$5 Copay Individual; $2 copay Group	$15 Copay Individual; $7 Copay Group	$20 copay Individual; $10 Copay Group

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Prescription Drug Benefits			
Retail Pharmacies			
Generic	$5 copay	$10 copay	$10 copay
Brand (Formulary/Preferred)	$5 copay	$30 copay	$30 copay
Brand (Non-Formulary/Non-preferred)	$5 copay (when approved) 20% coinsurance not to exceed	$30 copay (when approved) 20% coinsurance not to exceed	$30 copay (when authorized) 20% coinsurance not to exceed
Specialty Drugs	$150/prescription (30 days)	$150/prescription (30 days)	$150/prescription
Days Supply	100 days	100 days	30 days
Mail Order			
Generic	$5 copay	$10 copay	$20 copay
Brand (Formulary/Preferred)	$5 copay	$30 copay	$60 copay
Brand (Non-Formulary/Non-preferred)	$5 copay (when approved) 20% coinsurance not to exceed	$30 copay (when approved) 20% coinsurance not to exceed	$90 copay 20% coinsurance not to exceed
Specialty Drugs	$150/prescription (30 days)	$150/prescription (30 days)	$150/prescription (30 days)
Days Supply	100 days	100 days	100 days
Other Services and Supplies			
Vision Materials (Eyeglasses or contact lenses)	$175 Allowance every 24 months	$175 Allowance every 24 months	Not Covered
Durable Medical Equipment & Prosthetic Devices	100% in accordance with DME formulary	100% in accordance with DME formulary	20% in accordance with DME formulary
Home Health Care	$0 Copay, Up to 100 visits/year	$0 Copay, Up to 100 visits/year	$0 copay; Up to 100 visits/yr
Skilled Nursing or Extended Care Facility	$0 copay up to 100 days/benefit period	$0 copay up to 100 days/benefit period	10% coinsurance; up to 100 days/benefit period
Hospice Care	$0 copay	$0 copay	$0 copay
Chiropractic Services	$5 copay; up to 20 visits/yr	$5 copay; up to 20 visits/yr	$5 copay, up to 20 visits/year
Acupuncture Services	$5 copay; Physician referral required	$15 copay; Physician referral required	$20 copay; Physician referral required
Infertility Diagnosis/Treatment	$5 copay; See EOC for details	$15 copay; See EOC for details	50% coinsurance
Monthly Premiums			
EE Only	$1,194.72	$1,144.74	$1,054.46
EE +1 Dep	$2,389.44	$2,289.48	$2,108.92
EE + Family	$3,381.06	$3,239.61	$2,984.12