Casa Allegra

2021 Snapshot of Benefits

Casa Allegra is proud to provide a choice of two Kaiser medical plans for you to choose from: Kaiser Gold 80 HMO 250/35 and Kaiser Silver 70 HMO 2250/50. If you enroll in the Kaiser Silver Plan, you will pay $23 per month. If you enroll in the Gold Plan, you will pay $46 per month. A Dental plan is available to you with Guardian. If you enroll, you will pay $50.24 per month for yourself. If you want to enroll dependents, the cost is $101.98 for Employee & Spouse, or $125.59 for Employee & child(ren), or $195.07 for Employee & family. All active employees working 30+ hours per week are eligible for group medical coverage on the 1st of the month following 90 days of employment

Kaiser Medical Plans

	Gold 80 HMO 250/35	Silver 70 HMO 2250/50
General Plan Information		
Annual Deductible – Single/Family	$250/$500	$2,250/$4,500
Annual Out-of-Pocket Max – Single/Family	$7,800/$15,600	$8,200/$16,400
Coinsurance (What You Pay)	None	30%
Office Visit /Non-Specialist	$35 copay deductible waived	$55 copay deductible waived
Preventive Care	No charge, no deductible	No charge, no deductible
Acupuncture	$15 copay deductible waived	$55 copay deductible waived
Chiropractic Care	Not covered	Not covered
Lifetime Maximum Benefit	Unlimited	Unlimited
Hospital & Surgical Services		
Inpatient Hospital	$600 copay after deductible (up to 5 days)	30% after deductible
Emergency Room (waived if admitted)	$250 copay after deductible	30% after deductible
Urgent Care	$35 copay deductible waived	$55 copay deductible waived
Outpatient Surgery	$335 copay after deductible	30% deductible waived
Retail Prescription Drugs (30-day supply)		
Prescription Deductible	None	$300 Individual / $600 Family for all Tiers
Tier 1	$15 copay	$17 copay
Tier 2	$40 copay	$80 copay after deductible
Tier 3	$40 copay	$80 copay after deductible
Tier 4	20% (up to $250 per fill)	30% (up to $250 per fill) after deductible
	Contact Information	
Website / Customer Service	www.kp.org / 800-464-4000	

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Guardian Dental Plan

	Dental Guard Alliance Network	**Dental Guard Preferred Network**	**Non-Network**
Annual Deductible	$25 Individual / $50 Family	$50 Individual / $150 Family	$50 Individual / $150 Family
Calendar Year Maximum	$1,500 (Annual Maximum Combined for In and Out of Network)		
Preventive Care	No charge	No charge, no deductible	No charge, no deductible
Basic Care	10% after deductible	20% after deductible	20% after deductible
Major Care	40% after deductible	50% after deductible	50% after deductible
	Contact Information		
Website / Customer Service: Plan #00567326	**www.GuardianAnytime.com** / 888-600-1600 click on **"Find a Provider"**		