Murrieta Valley Unified School District

Kaiser Plan Comparison - All Employees



Effective Date	7/1/2025	7/1/2025	7/1/2025	7/1/2025	7/1/2025
Carrier	//1/2025	//1/2025	//1/2025	//1/2025	//1/2025
Carrier	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Compan
Plan Name	HMO 25 w/Chiro	DHMO 500 w/Chiro	DHMO HSA w/Chiro	DHMO 2500 Virtual Complete	HMO MVP
Benefit Summary	All Employees	Eligible Employees	Eligible Employees	Eligible Employees	Eligible Employees
General Plan Information					
Annual Deductible/Individual	\$0	\$500	\$1,650 medical/prescription combined	\$2,500	\$4,500
Annual Deductible/Family	\$0	\$1,000	\$3,300 (two or more members) medical/prescription combined	\$2,500 for each member in a family of two or more members. \$5,000 for an entire family of two or more members.	\$9,000
Coinsurance	100%	80%	90%	80%	60%
Office Visit/Exam	\$25 copay	\$20 copay	90% after deductible	\$40 copay after Plan Deductible (Plan Deductible doesn't apply to the first three visits combined for primary care, urgent care, mental health and substance use disorder treatment services).	\$50 copay; after deductible
Outpatient Specialist Visit	\$25 copay	\$20 copay	90% after deductible	\$40 copay	\$50 copay; after deductible
Annual Out-of-Pocket Limit/Individual	\$1,500	\$3,000	\$3,000	\$5,500	\$6,000
Annual Out-of-Pocket Limit/Family	\$3,000	\$6,000	\$6,000	\$5,500 for each member in a family of two or more members. \$11,000 for an entire family of two or more members.	\$12,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services					
Inpatient Hospitalization	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Emergency Services					
Emergency Room	\$100 copay waived if admitted	80% after deductible	90% after deductible	80% after deductible	\$250 copay; after deductible
Mental Health Benefits					
Inpatient Care	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Outpatient Care	\$25 copay	\$20 copay; deductible waived	90% after deductible	\$40 per visit for individual and \$20 per visit for group treatment	\$50 copay; after deductible
Alcohol Abuse					
Inpatient Care					
Inpatient Hospitalization	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Inpatient Detoxification Services	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Outpatient Care	,,			,-	74
Outpatient Services	\$25 copay	\$20 copay; deductible waived	90% after deductible	\$40 copay per visit for individual and \$5 per visit for group treatment	\$50 copay; deductible waived
Outpatient Detoxification Services	\$25 copay	\$20 copay; deductible waived	90% after deductible	\$40 copay per visit for individual and \$5 per visit for group treatment	\$50 copay; after deductible
Substance Abuse					
Inpatient Care					
Inpatient Hospitalization	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Inpatient Detoxification Services	100%	80% after deductible	90% after deductible	80% after deductible	60% after deductible
Outpatient Care					
Outpatient Services	\$25 copay	\$20 copay; deductible waived	90% after deductible	\$40 copay per visit for individual and \$5 per visit for group treatment	\$50 copay; after deductible
Outpatient Detoxification Services	\$25 copay	\$20 copay; deductible waived	90% after deductible	\$80 copay after deductible	\$50 copay; after deductible

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Saiser Permanente Insurance Company Saiser	ffective Date	7/1/2025	7/1/2025	7/1/2025	7/1/2025	7/1/2025
All Employees Eight Employee	rier	Kaiser Permanente Insurance Company				Kaiser Permanente Insurance Company
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100 per Member/salerdar yeer 1316 coppy 1310 coppy (member of a second of a s	fit Summary	All Employees	Eligible Employees	Eligible Employees	Eligible Employees	Eligible Employees
\$1.00 per Member/calendar year					ų į	
10 copy 10 c	scription Drug Deductible	N/A	\$100 per Member/calendar year			\$250 per Member/calendar year
\$30 copy; after prescription deductable of the control of the co	neric	\$15 copay	\$10 copay; deductible waived		\$15 copay, deductible waived	\$15 copay; deductible waived
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Sample S	iropractic Services	provided through American Specialty	provided through American Specialty	\$10 copay after deductible; 20 visits/calendar year; provided through	provided through American Specialty	provided through American Specialty
Dental PPO						
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Life \$6.75 \$5.75 \$5.75 \$6.75 \$5.75 Medical Premium* 1. Cap \$5916.67 \$5916.67 \$5916.67 Oeha Dental 1. Y Employee Cost \$983.50 \$701.91 \$604.13 \$553.58 Vuision 1. September 2. September 2					<u> </u>	MVP Tiered Rates
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ly Employee Cost \$983.50 \$701.91 \$604.13 \$553.58 Vision Group Life District Cap Premium Cost Employee & Spouse Medical Premium* Delta Dental Vision Group Life District Cap Premium Cost Employee & Child(ren) Medical Premium* Delta Dental Vision Group Life District Cap Premium Cost Employee & Child(ren) Medical Premium* Delta Dental Vision Group Life District Cap Premium Cost Employee & Child(ren) Medical Premium* Delta Dental Vision Group Life District Cap Premium Cost Employee & Child(ren) Medical Premium* Delta Dental Vision Group Life Group Life Group Life Group Life Group Life						Medical Premium*
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