Murrieta Valley Unified School District

Kaiser Plan Comparison - All Employees

Keenan RENEWAL 2025

Effective Date	7/1/2025	7/1/2025	7/1/2025	7/1/2025	7/1/2025
Carrier	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**
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					
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

Murrieta Valley Unified School District
Kaiser Plan Comparison - All Employees

Keenan RENEWAL 2025

Effective Date	7/1/2025	7/1/2025	7/1/2025	7/1/2025	7/1/2025
Carrier	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**
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
Prescription Drug Benefits					
Prescription Drug Deductible	N/A	$100 per Member/calendar year	$1,650 ind/$3,300 fam; medical/prescription combined		$250 per Member/calendar year
Generic	$15 copay	$10 copay; deductible waived	$10 copay; after deductible	$15 copay, deductible waived	$15 copay; deductible waived
Brand (Formulary/Preferred)	$35 copay	$30 copay; after $100 prescription deductible	$30 copay; after deductible	$40 copay after deductible	$35 copay; after prescription deductible
Number of Days Supply	30 days	30 days	30 days		30 days
Mail Order				30 days	
Generic	$30 copay	$20 copay; deductible waived	$20 copay; after deductible	$30 copay; deductible waived	$30 copay; deductible waived
Brand (Formulary/Preferred)	$70 copay	$60 copay; after $100 prescription deductible	$60 copay; after deductible	$80 copay after deductible	$70 copay; after prescription deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days	100 days
Other Services and Supplies			30 days		
Chiropractic Services	$10 copay; 30 visits/calendar year; provided through American Specialty Health	$10 copay; 30 visits/calendar year; provided through American Specialty Health	$10 copay after deductible; 20 visits/calendar year; provided through American Specialty Health	$10 copay; 30 visits/calendar year; provided through American Specialty Health	$10 copay; 30 visits/calendar year; provided through American Specialty Health

*Premiums below are based on an 8 hour / 100% Contract employee and Delta Dental PPO per month

Medical Premium*	**$1,751.28**	**$1,469.69**	**$1,371.91**	**$1,321.36**
Delta Dental PPO	**$111.79**	**$111.79**	**$111.79**	**$111.79**
Vision	**$30.35**	**$30.35**	**$30.35**	**$30.35**
Group Life	**$6.75**	**$6.75**	**$6.75**	**$6.75**
District Cap	**-$916.67**	**-$916.67**	**-$916.67**	**-$916.67**
Monthly Employee Cost	**$983.50**	**$701.91**	**$604.13**	**$553.58**

MVP Tiered Rates

Single	
Medical Premium*	**$547.12**
Delta Dental	**$111.79**
Vision	**$30.35**
Group Life	**$6.75**
District Cap	**-$916.67**
Premium Cost	**$0.00**
Employee & Spouse	
Medical Premium*	**$1,202.26**
Delta Dental	**$111.79**
Vision	**$30.35**
Group Life	**$6.75**
District Cap	**-$916.67**
Premium Cost	**$434.48**
Employee & Child(ren)	
Medical Premium*	**$1,093.07**
Delta Dental	**$111.79**
Vision	**$30.35**
Group Life	**$6.75**
District Cap	**-$916.67**
Premium Cost	**$325.29**
Family	
Medical Premium*	**$1,639.02**
Delta Dental	**$111.79**
Vision	**$30.35**
Group Life	**$6.75**
District Cap	**-$916.67**
Premium Cost	**$871.24**