

Newport-Mesa USD	Kaiser	Cigna Select	Cigna	Cigna	
2024 - 25 Medical Plan Options Actives	HMO	SELECT (HMO)	NETWORK (HMO)	OPEN ACCESS PLUS (OAP)	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS					
Calendar Year Deductible (Ind / Fam)	None	None	None	\$1,000 / \$3,000	\$1,500 / \$4,500
Annual Out of Pocket Max (Ind / Fam)	\$1,500 / \$3,000	\$1,000 / \$2,000	\$1,500 / \$3,000	\$4,000 / \$12,000	\$6,000 / \$18,000
PHYSICIAN SERVICES					
PCP Office Visits	\$5 co-pay	\$5 co-pay	\$25 co-pay	\$60 co-pay	50% after Ded
Specialist Office Visit	\$10 co-pay	\$10 co-pay	\$30 co-pay	\$70 co-pay	50% after Ded
	kp.org	TeleHealth			
Online Visit / Services	No co-pay	\$5 co-pay	\$25 co-pay	\$40 co-pay	Not Available
PREVENTIVE CARE					
Preventive Care / Immunizations Mammogram / PAP / PSA	No co-pay	No co-pay	No co-pay	No co-pay (Ded. waived)	Birth to Age 16 - 50% Age 17 & up Not Covered
INPATIENT					
Inpatient Hospital Facility / Delivery Facility	\$250 admit	\$250 admit then no co-pay	\$250 admit then no co-pay	\$250 admit + 20% after Ded	\$500 admit + 50% after Ded
OUTPATIENT					
Outpatient Facility	\$5 or \$10 co-pay	\$25 co-pay	\$25 co-pay	20% after Ded	50% after Ded
Emergency Room co-pay	\$150 co-pay	\$150 co-pay (Waived if admitted)	\$150 co-pay (Waived if admitted)	\$250 co-pay after deductible (co-pay waived if admitted)	
Urgent Care	\$5 co-pay	\$25 co-pay (Waived if admitted)	\$25 co-pay (Waived if admitted)	\$55 co-pay after Ded (Waived if admitted)	
Ambulance Services	\$50 co-pay	No co-pay	No co-pay	20% after Ded	
PRESCRIPTIONS					
	Network Only	Network Only	Network Only	In Network	Out of Network
Retail Generic/ Day Supply	\$5 co-pay/ 100 days	\$5 co-pay/ 30 days	\$5 co-pay/ 30 days	\$10 co-pay/ 30 days	Not Covered
Preferred Brand/ Day Supply	\$35 co-pay/ 100 days	\$35 co-pay/ 30 days	\$35 co-pay/ 30 days	\$35 co-pay/ 30 days	Not Covered
Non Preferred/Specialty Day Supply	\$60 co-pay/ 30 days	\$50 co-pay/ 30 days	\$50 co-pay/ 30 days	\$50 co-pay/ 30 days	Not Covered
Home Delivery-Generic /Day Supply	\$5 co-pay/ 100 days	\$5 co-pay/ 90 days	\$5 co-pay/ 90 days	\$20 co-pay/ 90 days	Not Covered
Home Delivery Preferred Brand/ Day Supply	\$35 co-pay/ 100 days	\$35 co-pay/ 90 days	\$35 co-pay/ 90 days	\$70 co-pay/ 90 days	Not Covered
Home Delivery-Non Preferred/ Specialty Day Supply	\$60 co-pay/ 30 days	\$50 co-pay/ 90 days	\$50 co-pay/ 90 days	\$100 co-pay/ 90 days	Not Covered

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OTHER BENEFITS					
Chiropractic	\$15 co-pay 30 visits calendar year	\$15 co-pay (Rider) unlimited days	\$25 or \$30 PCP / Specialist co-pay (Rider) 24 visits calendar year	\$60 or \$70 PCP / Specialist co-pay 20 visits per calendar year	50% after Ded
Physical Therapy	\$5 co-pay unlimited days	\$5 co-pay / \$10 Specialist unlimited days	\$25 or \$30 PCP / Specialist co-pay unlimited days	\$60 or \$70 PCP / Specialist co-pay 20 visits per calendar year	50% after Ded
Allergy Treatment	\$5 or \$10 PCP / Specialist copay	\$5 or \$10 PCP / Specialist copay	\$25 or \$30 PCP / Specialist co-pay	\$60 or \$70 PCP / Specialist co-pay	50% after Ded
Acupuncture	Not Covered	Not Covered	Not Covered	\$60 or \$70 PCP / Specialist co-pay 12 days max per cal year	50% after Ded
Diagnostic X-ray and Lab	No co-pay	No co-pay	No co-pay	Applicable office copay applies	50% after Ded
Advanced Imaging	No co-pay	No co-pay	No co-pay	\$65 co-pay per scan 20% Outpt Facility after Ded	50% after Ded
Durable Medical Equipment	No co-pay	No co-pay	No co-pay	20% after Ded	50% after Ded
Hearing Aids	\$3,000 max allowable per 36 months (per ear)	\$5,000 max allowable per calendar year	\$5,000 max allowable per calendar year	20% after Ded	50% after Ded
				\$5,000 max allowable benefit every 3 years (after deductible)	
Breast feeding Equipment and Supplies	No co-pay	No co-pay	No co-pay	No co-pay	Not Covered
Infertility Testing	50% per visit	\$5 PCP / \$10 Specialist Office or \$25 facility co-pay	\$25 or \$30 PCP / Specialist co-pay	Covered like any other Physician Office In & Out of Network, up to Diagnosis	
Organ & Tissue Transplants	\$250 admit	\$250 admit then no co-pay	\$250 admit then no co-pay	\$250 admit + 20% after Ded (Non Life Source Facility)	Not Covered
Skilled Nursing Care (Utilization review required for skilled nursing facility stay) 100 calendar days	No co-pay	No co-pay	No co-pay	20% after Ded	50% after Ded
Home Health Limited to 100 calendar days.	No co-pay	No co-pay	No co-pay	20% after Ded	50% after Ded
Hospice	No co-pay	No co-pay	No co-pay	20% after Ded	50% after Ded
Mental Health & Substance Abuse					
Inpatient Care Facility-based care	\$250 admit	\$250 admit then no co-pay	\$250 admit then no co-pay	\$250 admit + 20% after Ded	\$500 admit + 50% after Ded
Outpatient Care	\$5 per individual visit / \$2 per visit group	\$5 Office co-pay	\$30 Office co-pay	\$70 co-pay	50% after Ded
<p>Note: This is a snapshot summary for comparison and general information, it is not intended to replace the Summary of Benefit Coverage.</p> <p>For more plan specifics see Newport-Mesa USD's insurance certificate, Summary of Benefit Coverage at www.nmusd.us/benefits.</p>					