Westminster Public Schools

Insurance Plans Highlight Comparison Sheet (effective January 1, 2026 - December 31, 2026)

The table below summarizes the key features of the medical plans. The coinsurance amounts listed reflect the amount the plan pays. Please refer to the official plan document for additional information on coverage and exclusions. Benefit changes are shown in **BOLD** font.

Summary of Covered Benefits	Kaiser DHMO 1000	Kaiser 220 High HMO	Kaiser ACDC Coinsurance POS		
	In-Network Only	In-Network Only	Plan Provider	Participating Provider	Non-Participating Provider
Annual Deductible					
Individual	$1,000	None	$1,000	$2,000	$3,500
Family	$3,000	None	$2,000	$4,000	$10,500
Out-of-pocket Maximum	Includes ded., coinsurance, and all copays	Includes all copays	Includes ded., coinsurance, and all copays		
Individual	$3,500	$4,000	$3,000	$4,000	$8,000
Family	$7,000	$8,000	$6,000	$8,000	$24,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited		
Coinsurance	90%	N/A	90%	80%	60%
Physician Services					
Primary Care Physician	$30 copay*	$25 copay	$35 copay*	$50 copay*	Ded., 60%
Specialist	$45 copay*	$40 copay	$50 copay*	$65 copay*	Ded., 60%
Preventive Care					
Child/Adult	100% covered	100% covered	100% covered	100% covered	Ded., 60%
Urgent Care (Kaiser after hours clinic)					
After-Hours Care	$45 copay	$75 copay	$50 copay		
Hospital Services					
Inpatient	Ded., 90%	$1,000 copay	Ded., 90%	Ded., 80%	Ded., 60%
Outpatient Surgery, Surgery Center / Hospital	$500 copay / Ded., 90%	$500 copay / $1,000 copay	$500 copay / Ded, 90%	Ded., 80%	Ded., 60%
Emergency Room	Ded., 90%	$500 copay	Ded., 90%		
Lab/X-Ray					
Diagnostic Lab	100% covered	100% covered	100% covered	Ded., 80%	Ded., 60%
Diagnostic X-Ray	Ded., 90%	100% covered	Ded., 90%	Ded., 80%	Ded., 60%
High Tech (MRI, CT scans)	Ded., 90%	$250 copay per test	Ded., 90%	Ded., 80%	Ded., 60%
Prescriptions					
Generic	$25 copay	$15 copay	$25 copay	$30 copay	50%
Brand	$50 copay	$40 copay	$40 copay	$45 copay	50%
Non-Preferred Brand	$70 copay	$60 copay	50%	50%	50%
Specialty	20% up to $250	20% up to $250	20% up to $250	20% up to $250	50%
Mail Order	2x retail copay	2x retail copay	2x retail copay	2x retail copay	N/A
Therapies					
Therapies Limits	20 visits per therapy per year	20 visits per therapy per year	20 visits per therapy per year		
PT,OT, & Speech Therapy	$30 copay	$25 copay	$35 copay	$50 copay	Ded., 60%
Chiropractic Limits	20 visits per year	20 visits per year	20 visits per therapy per year		Not covered
Chiropractic Care	$30 copay	$25 copay	$35 copay	$35 copay	Not covered
Vision					
Refractive Exam	$30 copay	$25 copay	$35 copay*	$50 copay*	Ded., 60%
Hardware	Not covered	Not covered	Not covered	Not covered	Not covered
Employee	$0.00	$86.98	$157.39		
Employee + Spouse	$273.69	$447.64	$642.23		
Employee + Child(ren)	$95.73	$247.93	$418.20		
Family	$899.60	$1,168.35	$1,469.00		

NOTE: This summary is for illustrative purposes only. Any discrepancies between this summary and the plan documents, the plan documents will prevail.

*Coinsurance may apply for covered services received during a visit