

Newport-Mesa USD	Kaiser	SCAN		Cigna	
2026 - 27 Medical Plan Options Retirees Age 65+	Senior Advantage So CA Only	Medicare Advantage Select CA Counties		OAP - Medicare Expand Nationwide except HI	
	Network Only	Basic	Enhanced	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS					
Calendar Year Deductible (Ind / Fam)	None	None	None	\$2,000 / \$6,000	\$2,500 / \$7,500
Annual Out of Pocket Max (Ind / Fam)	\$1,000 / \$3,000	\$3,400	\$3,400	\$6,000 / \$18,000	\$8,000 / \$24,000
PHYSICIAN SERVICES					
PCP/Specialist Office Visits	\$15 Co-pay	\$15 Co-pay	\$10 Co-pay	\$60 Co-pay / \$70 Co-pay	50% after Ded
	kp.org	TeleHealth		TeleHealth	
Online Visits	No Co-pay	\$0 Co-pay	\$0 Co-pay	\$40 co-pay	Not Available
PREVENTIVE CARE					
Preventive Care / Immunizations	No Co-pay	No Co-pay	No Co-pay	No Co-pay	Birth to Age 16 - 50% Age 17 & up Not Covered
Mammogram / PAP / PSA	No Co-pay	No Co-pay	No Co-pay	No Co-pay	50% after Ded
INPATIENT					
Inpatient Hospital Facility	\$250/admit	\$100/admit	No Co-pay	\$250/admit + 20% after Ded	\$500/admit + 50% after Ded
Inpatient Professional Services	No Co-pay	No Co-pay	No Co-pay	20% after Ded	50% after Ded
OUTPATIENT					
Outpatient Facility	\$50 procedure Co-pay \$15 visit	No Co-pay	No Co-pay	20% after Ded	50% after Ded
Emergency Room Co-pay	\$50 Co-pay	\$25 Co-pay (Waived if admitted)	\$50 Co-pay (Waived if admitted)	\$250 Co-pay after Ded (Waived if admitted)	
Urgent Care	\$15 Co-pay	\$25 Co-pay	\$10 Co-pay	\$55 Co-pay after Ded	
Ambulance Services	\$50 Co-pay	No Co-pay	No Co-pay	20% after Ded	
PRESCRIPTIONS					
Tier 1 & 2 Generic/ Day Supply	\$10 Co-pay/100 days	\$5 Co-pay/ 30 days	\$5 Co-pay/ 30 days	T1: \$20 Co-pay/ 30 days	not covered
Tier 2 Non-Preferred Generic/ Day Supply	Not covered	\$10 Co-pay/ 30 days	\$10 Co-pay/ 30 days	not covered	not covered
Tier 3 Brand Name/ Day Supply	\$25 Co-pay/100 days	\$20 Co-pay/ 30 days	\$20 Co-pay/ 30 days	T2: \$50 Co-pay/30 days	not covered
Tier 4 Non-Preferred Brand/ Day Supply	Not covered	\$20 Co-pay/ 30 days	\$20 Co-pay/ 30 days	T3: \$80 Co-pay/30 days	not covered
Tier 5 Specialty drugs/ Day Supply	Not covered	25% Co-pay Home Delivery N/A	25% Co-pay Home Delivery N/A	Not Applicable see rates above	not covered
Home Delivery	Co-pay same as above 100 Days	Two Co-pays for 100 Days		\$50 / \$125 / \$200 for 90 Days	not covered

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OTHER BENEFITS					
Chiropractic	\$15 Co-pay	\$15 Co-pay	\$10 Co-pay	\$70 Co-pay	50% after Ded
	30 visits/calendar year	20 visits per calendar year		20 visits per calendar year	
Physical Therapy	\$15 Co-pay	\$5 Co-pay	No Co-pay	\$70 Co-pay	50% after Ded
				20 visits per calendar year	
Allergy Treatment	\$15 Co-pay	\$15 Co-pay	\$10 Co-pay	\$70 Co-pay or actual charge (if less)	50% after Ded
Acupuncture	Not covered	Not Covered		\$70 Co-pay	50% after Ded
				12 days max per cal year	
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	50% after Ded
Durable Medical Equipment	20% Coinsurance	No Co-pay	No Co-pay	20% after Ded	50% after Ded
Hearing Aids	No Co-pay	\$15 every 2 years	\$10 every 2 year	Office Co-pay applies	50% after Ded
	\$3,000 allowance per ear, every 36 months	\$2,000 allow 1 or 2 aids every 2 yrs	\$4,000 allow 1 or 2 aids every 2 yrs	\$5,000 max allowable benefit every 3 years	\$5,000 max allowable benefit every 3 years
Organ & Tissue Transplants	No Co-pay	\$100/admit then no Co-pay	\$0/admit then no Co-pay	\$250 admit + 20% after Ded (Non Life Source Facility)	Not covered
Vision	\$150 Eyewear Allow Every 24 mo.	\$15 Co-pay \$100 Eyewear Allow Every 24 mo.	\$10 Co-pay \$100 Eyewear Allow Every 24 mo.	Not covered	Not covered
Prosthetics & Orthotics	20% Co-pay	No Co-pay	No Co-pay	20% after Ded	50% after Ded
Home Health	\$0 Visit	\$0 - 15 Co-pay	\$0 - 15 Co-pay	20% after Ded 100 max days/cal yr	50% Co-pay 100 max days/cal yr
Skilled Nursing Care/ 100 calendar days (Utilization review required for skilled nursing facility stay)	No Co-pay	\$100/admit	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 per admit	\$100 admit	No Co-pay	\$250 admit + 20% after Ded	\$500 admit + 50% after Ded
Outpatient Care	\$15 per visit individual / \$7 Group Treatment	\$15 Co-pay	\$10 Co-pay	Applicable office copay applies	50% after Ded
Note: This is a snapshot summary for comparison and general information, it is not intended to replace the Summary of Benefit Coverage. For more plan specifics see Newport-Mesa USD's insurance certificate, Summary of Benefit Coverage at www.nmusd.us/benefits. Or from the contact information listed in the front of the Benefit Book.					