Plan Type (PPO or HMO)	HMO	PPO	PPO	PPO	PPO	PPO	PPO	HMO
Carrier (Anthem Blue Cross or Kaiser)	Kaiser	ProactiveCare	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem
District Name	LAKE ELSINORE UNIFIED							
Bargaining Unit	2026-2027 CLASSIFIED							Premier & Priority Select
2026-2027	Kaiser	ProactiveCare	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem
	$30 OV, $10-30 Rx (Non-Marketed)	Platinum	100-C $20	90-G $20	80-G $20	80-L $30	2-Tier HSA $5,000	Premier 20
SISC Cost Example Scenarios (PPO Plans Only)[1]								
Maternity Example		$400	$220	$1,000	$2,000	$4,000	$6,350	
Diabetes Example		$260	$840	$840	$840	$940	$5,120	
Fractured Foot Example		$1,550	$450	$1,010	$1,590	$2,810	$5,080	

[1]Examples are based on the federal SBC examples, but updated with actual SISC Costs.

MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$0	$0/$0	$200/$400	$500/$1,000	$500/$1,000	$2,000/$4,000	$5,000/$10,000*	$0/$0
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,500/$3,000	$2,000/$4,000	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$4,000/$8,000	$6,350/$12,700*	$1,500/$3,000

*Includes Rx

PROFESSIONAL SERVICES	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Primary Care* visit co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$30	$0	$20	$20	$20	$30	Deductible, then 30% after Ded	$20
Urgent Care co-pay	$30	$0	$20	$20	$20	$30	30% after Ded	$20
Prenatal, postnatal office visit co-pay	$0	$0	$20	$20	$20	$30	30% after Ded	$20
Specialists/Consultants co-pay	$30	$70	$20	$20	$20	$30	30% after Ded	$20
		Non-Hosp/OPH**						
Scans: CT, CAT, MRI, PET etc.	$0	$200/$500	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$100/test
Laboratory Procedures	$0	$0/$100	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$0
Diagnostic X-rays	$0	$50/$150	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$0
Infertility (Refer to Plan Document)	Co-pay applies	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	50%
Preventive Care (includes physical exams & screenings)	$0	$0	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	$0

HOSPITAL & SKILLED NURSING FACILITY SERVICES	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Emergency Room visit (copay waived if admitted) - **Avg Cost: $2,847 | $100+10%: $375 | $100+20%: $649**	$100	$600	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	30% after Ded $100 co-pay	$100
Inpatient Hospital (preauthorization required) - **Avg Cost for one day: $6,067 | 10%: $607 | 20%: $1,213**	$0	$400/day	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$200/admit
Surgery, Outpatient (performed in Surgery Center)	$30	$400	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$100
Surgery, Outpatient (performed in a Hospital) - limits may apply	$30	$1,200	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$100

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
INPATIENT: Facility Based Care (preauth required)	$0	$400/day	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$200
OUTPATIENT: Facility Based Care (preauth required)	$30	$0	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$0

OTHER SERVICES	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Ambulance (Ground or Air)	$50	$600	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	30% after Ded $100 co-pay	$100
Acupuncture - Limits apply	$10/30 visits (through ASH) combined w/chiro	$0	0% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	30% after Ded Subject to PA	$10/30 visits combined w/chiro
Chiropractic - Limits apply	$10/30 visits (through ASH) combined w/acu	$0	0% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	30% after Ded Subject to PA	$10/30 visits combined w/acu
Physical and Occupational Therapy - Limits apply	$30	$0	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	$20
Durable Medical Equipment (DME)	no charge	$0	0% after Ded	10% after Ded	20% after Ded	20% after Ded	30% after Ded	20%
Hearing Aids	amount in excess of $500 allowance every 36 months	$0 plus the amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	50% Coinsurance 1 device per ear/36 months

*Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

**"non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting

PHARMACY BENEFITS	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Plan	**$10-30 Rx (Non-Marketed)**	**Rx 9-35 PC**	**Rx 200/10-35**	**Rx 200/10-35**	**Rx 200/10-35**	**Rx 200/10-35**	**Rx HSA**	**Rx 200/10-35**
Pharmacy Benefit Manager	Kaiser	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	$200/$500	$200/$500	$200/$500	$200/$500	Included w/ Medical ded	$200/$500
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	$2,500/$3,500
Generic co-pay/30 days supply	$10 up to 100 day supply	$0 at Costco‡ $9 at Other Network	$0 at Costco‡ $10 at Other Network	$0 at Costco‡ $10 at Other Network	$0 at Costco‡ $10 at Other Network	$0 at Costco‡ $10 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	$0 at Costco‡ $10 at Other Network
Brand co-pay/30 days supply	$30 up to 100 day supply	$35	$35	$35	$35	$35	Deductible, then $35	$35
Specialty co-pay/up to 30 days supply	$30 up to 30 day supply	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)	$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	$10-$30/up to 100 day supply	$0-$90‡	$0-$90‡	$0-$90‡	$0-$90‡	$0-$90‡	Deductible, then $0-$90	$0-$90‡
Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Employee cost/payroll de can be requested from the district.

‡Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.