

# Certificated Benefit Information Sheet

## Kaiser Option for 2025-26 Benefit Plan Year (Oct. 2025 - Sept. 2026)

Brief Summary of Benefits		Member Pays:
<b>Professional Services:</b>		
Office Visit co-pay		\$10
Urgent Care co-pay		\$10
Specialists/Consultants co-pay		\$10
Prenatal, Postnatal Office Visit co-pay		\$0
Scans: CT, CAT, MRI, PET, etc.		\$0
Diagnostic X-ray & Laboratory Procedures		\$0
Preventative Care Services (includes physical exams & screenings)		\$0
<b>Hospital &amp; Skilled Nursing Facility Services:</b>		
Emergency Room (co-pay waived if admitted)		\$100 co-pay
Inpatient Hospital co-pay (preauthorization required)		\$0
Outpatient Hospital co-pay		\$10
Surgery, Outpatient (performed in an Ambulatory Surgery Center)		\$10
Surgery, Outpatient (performed in a Hospital)		\$10
<b>Mental Health Services &amp; Substance Abuse Treatment:</b>		
Inpatient Care: Facility based care (preauthorization required)		\$0
Outpatient Care: Facility based care (preauthorization required)		\$10
<b>Other Services:</b>		
Acupuncture - limits apply		\$10 co-pay / 30 visits
Ambulance (ground or air)		\$50
Chiropractic - limits apply		\$10 co-pay / 30 visits
Durable Medical Equipment (DME)		100%
Physical and Occupational Therapy - limits apply		\$10
<b>Individual / Family Deductible(s)</b> A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan - deductibles are per calendar year.		<b>\$0</b>
<b>Individual / Family - Out of Pocket Max (OOP Max)</b> - The OOP Max is the most you have to pay in deductibles, co-insurance and co-pays for covered health services during a calendar year. All deductibles and co-pays apply to the calendar year OOP maximum.		<b>\$1500 per individual \$3000 family</b>
<b>Outpatient Prescription Drugs</b>		
	<b>Days supply</b>	100
	Generic Cost	\$10
	Brand Name Cost	\$10
	Mail Order	\$10

This sheet is only a brief summary of benefits that reflects In-Network benefits. Visit our website at [hr.fcoe.org/benefits](http://hr.fcoe.org/benefits) to review the benefit summaries or plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

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<b>MONTHLY COSTS</b>	
Medical	\$1,602.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	\$1,737.85
TOTAL COST w/ Delta Dental PPO Plan	\$1,725.85
Employer Contribution/Monthly	\$1,495.83

<b>11 MONTH EMPLOYEE COST</b>	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$264.02
Employee's Cost/Monthly with Delta Dental PPO	\$250.93

<b>12 MONTH EMPLOYEE COST</b>	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$242.02
Employee's Cost/Monthly with Delta Dental PPO	\$230.02

**Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee**