Menifee Union Elementary - *Admin/Mgmt/Conf*

2025-2026 Plan Comparison & Summary

	1	2	3	4	5	6	7	8	9
	Anthem 90-C $20	**Anthem 80-M $40**	**Anthem 2-Tier HSA $5000 Single**	**Anthem 2-Tier HSA $5000 Single & Children**	**Anthem HSA $5,000 Family**	**Anthem RX: $200/$10-35 Classic 20/40/250 Admit**	**Anthem Value Deductible $2000 30/45/20%/ 3 day**	**Kaiser Trad HMO $30**	**Kaiser HSA $1700 Single / Family**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	**$200/$500**	**$3,000/$6,000**	**$5,000**	**$5,000/$10,000**	**$5,000/$10,000***	**$0/$0**	**$2,000/member**	**$0**	**$1,700***
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	**$1,000/$3,000**	**$4,000/$8,000**	**$6,350** *Includes Rx	**$6,350/$12,700** *Includes Rx	**$6,350/$12,700*** *Includes Rx	**$2,000/$4,000**	**$3,500/$7,000**	**$1,500/$3,000**	**$3,400*** *Includes Rx
PROFESSIONAL SERVICES									
Office Visit (OV) co-pay	$0 copay 1st 3 visits then $20	$0 copay 1st 3 visits then $40	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	$20	$30	$30	Deductible, then 10%
Urgent Care co-pay	$20	$40	30%	30%	30%	$20	$30	$30	10%
Specialists/Consultants co-pay	$20	$40	30%	30%	30%	$40	$45	$30	10%
Prenatal, postnatal office visit co-pay	$20	$40	30%	30%	30%	$20	$30	$0	$0
Scans: CT, CAT, MRI, PET etc.	10%	20%	30%	30%	30%	$100/test	$100/test	$0	$0
Diagnostic X-ray & Laboratory Procedures	10%	20%	30%	30%	30%	$0	$0	$0	10%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered	Not covered	50%	50%	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	$0	$0	$0	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES									
Emergency Room visit (copay waived if admitted)	10% $100 Co-pay	20% $100 Co-pay	30% $100 Co-pay	30% $100 Co-pay	30% $100 Co-pay	$100	$200 Copay / 25% after Ded.	$100	10%
Inpatient Hospital (preauthorization required) - limits may apply	10%	20%	30%	30%	30%	$250/admit	20% after Ded.	$0	10%
Outpatient Hospital	10%	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	10%
Surgery, Outpatient (performed in Surgery Center)	10%	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	10%
Surgery, Outpatient (performed in a Hospital) - limits may apply	10%	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	10%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT									
INPATIENT: Facility Based Care (preauth required)	10%	20%	30%	30%	30%	$250/admit	$250/admit	$0	10%
OUTPATIENT: Facility Based Care (preauth required)	10%	20%	30%	30%	30%	$0	$0	$30	10%
OTHER SERVICES									
Ambulance (Ground or Air)	10% $100 Co-pay	20% $100 Co-pay	30% $100 Co-pay	30% $100 Co-pay	30% $100 Co-pay	$100	$100	$50	10%
Acupuncture - Limits apply	10% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network	$10/30 visits combined w/chiro	$10/30 visits combined w/chiro	$10/30 visits (through ASH) combined w/chiro	Requires Prior Authorization
Chiropractic - Limits apply	10% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network	$10/30 visits combined w/acu	$10/30 visits combined w/acu	$10/30 visits (through ASH) combined w/acu	No coverage
Durable Medical Equipment (DME)	10%	20%	30%	30%	30%	20%	20%	No charge	10%
Physical and Occupational Therapy - Limits apply	10%	20%	30%	30%	30%	$40	$40	$30	10%
Hearing Aids	10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	50% Coinsurance 1 device per ear/36 months	50% Coinsurance 1 device per ear/36 months	Amount in excess of $500 allowance every 36 months	No coverage
PHARMACY BENEFITS									
Plan	200/10-35	200/10-35	HSA Rx	HSA Rx	HSA Rx	200/10-35	200/10-35	Trad HMO $30	HSA A
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	$200/$500	$200/$500	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded	$200/$500	$200/$500	None	Included w/ Medical Ded.
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco $10 at Other Network	$0 at Costco $10 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	$0 at Costco $10 at Other Network	$0 at Costco $10 at Other Network	$10 up to 100 day supply	Deductible, then $10
Brand co-pay/30 days supply	$35	$35.00	Deductible, then $35	Deductible, then $35	Deductible, then $35	$35.00	$35.00	$30 up to 100 day supply	Deductible, then $30
Specialty co-pay/up to 30 days supply	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)	Deductible, then $35 (Must Use Navitus Mail)	Deductible, then $35 (Must Use Navitus Mail)	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$30 up to 30 day supply	Deductible, then $30
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$90	$0-$90	Deductible, then $0-$90	Deductible, then $0-$90	Deductible, then $0-$90	$0-$90	$0-$90	$10-$30/up to 100 day supply	$20-$60/up to 100 day supply
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	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.