

Menifee Union Elementary - *Classified*

2025-2026 Plan Comparison & Summary

	7	8	9
	Kaiser Trad HMO \$30	Kaiser Ded HMO \$1,000	Kaiser HSA \$3400
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0	\$1,000/\$2,000	\$3,400/\$6,800*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	\$1,500/\$3,000	\$3,000/\$6,000	\$6,000/\$12,000*

PROFESSIONAL SERVICES

Office Visit (OV) co-pay	\$30	\$20	Deductible, then 20%
Urgent Care co-pay	\$30	\$20	20%
Specialists/Consultants co-pay	\$30	\$20	20%
Prenatal, postnatal office visit co-pay	\$0	\$0	\$0
Scans: CT, CAT, MRI, PET etc.	\$0	20% Copay up to \$50	20%
Diagnostic X-ray & Laboratory Procedures	\$0	\$10	20%
Infertility (Refer to Plan Document)	Co-pay applies	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	\$0	0% Ded Waived	0% Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (copay waived if admitted)	\$100	20%	20%
Inpatient Hospital (preauthorization required) - limits may apply	\$0	20%	20%
Outpatient Hospital	\$30	20%	20%
Surgery, Outpatient (performed in Surgery Center)	\$30	20%	20%
Surgery, Outpatient (performed in a Hospital) - limits may apply	\$30	20%	20%

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	\$0	20%	20%
OUTPATIENT: Facility Based Care (preauth required)	\$30	20%	20%

OTHER SERVICES

Ambulance (Ground or Air)	\$50	\$150	20%
Acupuncture - Limits apply	\$10/30 visits (through ASH) combined w/chiro	\$10/30 visits (through ASH) combined w/chiro	Requires Prior Authorization
Chiropractic - Limits apply	\$10/30 visits (through ASH) combined w/acu	\$10/30 visits (through ASH) combined w/acu	no coverage
Durable Medical Equipment (DME)	no charge	20%	20%
Physical and Occupational Therapy - Limits apply	\$30	\$20	20%
Hearing Aids	amount in excess of \$500 allowance every 36 months	amount in excess of \$500 allowance every 36 months	no coverage

PHARMACY BENEFITS

Plan	Trad HMO \$30	Ded HMO \$1000	HSA B
Pharmacy Benefit Manager	Kaiser	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$10 up to 100 day supply	\$10.00	deductible, then \$10
Brand co-pay/30 days supply	\$30 up to 100 day supply	\$30.00	deductible, then \$30
Specialty co-pay/up to 30 days supply	\$30 up to 30 day supply	\$30.00	20% (not to exceed \$150)
Mail Order (Generic-Brand co-pay/90 days supply)	\$10-\$30/up to 100 day supply	\$20-\$60/up to 100 day supply	\$20-\$60/up to 100 day supply
Mail Order Pharmacy	Kaiser 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.