

# Menifee Union Elementary - *Admin/Mgmt/Conf*

## 2025-2026 Plan Comparison & Summary

	3	4	5
	2-Tier HSA 5000 Single	2-Tier HSA 5000 Single & Children	HSA \$5000 Family
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
<b>Individual/Family Deductibles</b>	<b>\$5,000</b>	<b>\$5,000/\$10,000</b>	<b>\$5,000/\$10,000*</b>
<b>Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)</b>	<b>\$6,350</b>	<b>\$6,350/\$12,700</b>	<b>\$6,350/\$12,700*</b>

### PROFESSIONAL SERVICES

Office Visit (OV) co-pay	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
Urgent Care co-pay	30%	30%	30%
Specialists/Consultants co-pay	30%	30%	30%
Prenatal, postnatal office visit co-pay	30%	30%	30%
Scans: CT, CAT, MRI, PET etc.	30%	30%	30%
Diagnostic X-ray & Laboratory Procedures	30%	30%	30%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived

### HOSPITAL & SKILLED NURSING FACILITY SERVICES

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

### MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	30%	30%	30%
OUTPATIENT: Facility Based Care (preauth required)	30%	30%	30%

### OTHER SERVICES

Ambulance (Ground or Air)	30% \$100 Co-pay	30% \$100 Co-pay	30% \$100 Co-pay
Acupuncture - Limits apply	30% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network
Chiropractic - Limits apply	30% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network
Durable Medical Equipment (DME)	30%	30%	30%
Physical and Occupational Therapy - Limits apply	30%	30%	30%
Hearing Aids	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

### PHARMACY BENEFITS

Plan	HSA Rx	HSA Rx	HSA Rx
Pharmacy Benefit Manager	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	Included w/ Medical ded	Included w/ Medical ded	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	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
Brand co-pay/30 days supply	Deductible, then \$35	Deductible, then \$35	Deductible, then \$35
Specialty co-pay/up to 30 days supply	Deductible, then \$35 (Must Use Navitus Mail)	Deductible, then \$35 (Must Use Navitus Mail)	Deductible, then \$35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	Deductible, then \$0-\$90	Deductible, then \$0-\$90	Deductible, then \$0-\$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco 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.