November 21, 2024

Menifee Union School District

2025-2026 SISC Medical Plan Options (Classified)

				Spouse Included						Spouse Included
	Anthem 80-M $40	**Anthem 2-Tier HSA 5000 - Single**	**Anthem 2-Tier HSA 5000 - Family**	**Anthem HSA $5000**	**Anthem RX: $200/$10-35 Classic 20/40/250 Admit**	**Anthem Value Ded 2000 30/45/20%/ 3 day**	**Kaiser Trad HMO $30**	**Kaiser Ded HMO $1,000**	**Kaiser HSA $3400**
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	$3,000/$6,000	$5,000*	$5,000/$10,000*	$5,000/$10,000*	$0/$0	$2,000/member	$0	$1,000/$2,000	$3,400/$6,800*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$4,000/$8,000	$6,350*	$6,350/$12,700*	$6,350/$12,700*	$2,000/$4,000	$3,500/$7,000	$1,500/$3,000	$3,000/$6,000	$6,000/$12,000*
Yearly Cost for the plan	$ 15,024.00	$ 8,592.00	$ 13,692.00	$ 13,416.00	19,440.00	15,804.00	20,436.00	18,528.00	14,172.00
Total Annual Cost Savings	$ 8,100.00			$ 276.00	408.00	4,044.00	828.00	2,736.00	7,092.00
Total Monthly Savings	$ 675.00			$ 23.00	34.00	337.00	69.00	228.00	591.00
		*Includes Rx	*Includes Rx	*Includes Rx					*Includes Rx
PROFESSIONAL SERVICES									
Office Visit (OV) co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$40	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	$20	$30	$30	$20	Deductible, then 20%
Urgent Care co-pay	$40	30%	30%	30%	$20	$30	$30	$20	20%
Specialists/Consultants co-pay	$40	30%	30%	30%	$40	$45	$30	$20	20%
Prenatal, postnatal office visit co-pay	$40	30%	30%	30%	$20	$30	$0	$0	$0
Scans: CT, CAT, MRI, PET etc.	20%	30%	30%	30%	$100/test	$100/test	$0	20% Copay up to $50	20%
Diagnostic X-ray & Laboratory Procedures	20%	30%	30%	30%	$0	$0	$0	$10	20%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered	50%	50%	Co-pay applies	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	$0	$0	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES									
Emergency Room visit (copay waived if admitted)	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay	30% $100 co-pay	$100	$200 Copay 25% after ded.	$100	20%	20%
Inpatient Hospital (preauthorization required) - limits may apply	20%	30%	30%	30%	$250/admit	20% after Ded.	$0	20%	20%
Outpatient Hospital	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	20%	20%
Surgery, Outpatient (performed in Surgery Center)	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	20%	20%
Surgery, Outpatient (performed in a Hospital) - limits may apply	20%	30%	30%	30%	$125/admit	20% after Ded.	$30	20%	20%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT									
INPATIENT: Facility Based Care (preauth required)	20%	30%	30%	30%	$250/admit	$250/admit	$0	20%	20%
OUTPATIENT: Facility Based Care (preauth required)	20%	30%	30%	30%	$0	$0	$30	20%	20%
OTHER SERVICES									
Ambulance (Ground or Air)	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay	30% $100 co-pay	$100	$100	$50	$150	20%
Acupuncture - Limits apply	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	$10/30 visits (through ASH) combined w/chiro	Requires Prior Authorization
Chiropractic - Limits apply	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	$10/30 visits (through ASH) combined w/acu	no coverage
Durable Medical Equipment (DME)	20%	30%	30%	30%	20%	20%	no charge	20%	20%
Physical and Occupational Therapy - Limits apply	20%	30%	30%	30%	$40	$40	$30	$20	20%
Hearing Aids	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	amount in excess of $500 allowance every 36 months	no coverage

PHARMACY BENEFITS

Plan	200/10-35	HSA Rx	HSA Rx	HSA Rx	200/10-35	200/10-35	Trad HMO $30	Ded HMO $1000	HSA B
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	$200/$500	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded	$200/$500	$200/$500	none	none	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$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	Included w/ Med OOP Max
Generic co-pay/30 days supply	$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	$10.00	deductible, then $10
Brand co-pay/30 days supply	$35.00	Deductible, then $35	Deductible, then $35	Deductible, then $35	$35.00	$35.00	$30 up to 100 day supply	$30.00	deductible, then $30
Specialty co-pay/up to 30 days supply	$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	$30.00	20% (not to exceed $150)
Mail Order (Generic-Brand co-pay/90 days supply)	$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	$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	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

*Coverage stages apply, see benefit summary for details

Subtract: Your District's Yearly Contribution	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00
Premium balance owed	5,024.00	-	3,692.00	3,416.00	9,440.00	5,804.00	10,436.00	8,528.00	4,172.00
Subtract: Your yearly Payroll Deduction	5,024.00	-	3,692.00	3,416.00	9,440.00	5,804.00	10,436.00	8,528.00	4,172.00
Yearly Premium Balance after deductions	-	-	-	-	-	-	-	-	-
ADD: Maximum OOP to pay for one, in worse medical year	4,000.00	6,350.00	6,350.00	6,350.00	2,000.00	3,500.00	1,500.00	3,000.00	6,000.00
Your total worse medical costs for one??	9,024.00	6,350.00	10,042.00	9,766.00	11,440.00	9,304.00	11,936.00	11,528.00	10,172.00
ADD: Maximum OOP to pay for two, in worse medical year	8,000.00	-	12,700.00	12,700.00	4,000.00	7,000.00	3,000.00	6,000.00	12,000.00
Your total worse medical costs for two??	13,024.00	-	16,392.00	16,116.00	13,440.00	12,804.00	13,436.00	14,528.00	16,172.00
ADD: Max OOP to pay for three or more, in worse medical year	8,000.00	-	12,700.00	12,700.00	4,000.00	7,000.00	3,000.00	6,000.00	12,000.00
Your total worse medical costs for three or more??	13,024.00	-	16,392.00	16,116.00	13,440.00	12,804.00	13,436.00	14,528.00	16,172.00