SISC
Self-Insured Schools of California
Schools Helping Schools

District Name BRAWLEY UNION HIGH SCHOOL DISTRICT
Bargaining Unit ALL

2020-2021	Anthem	Anthem	Anthem	Anthem
	100-A $20	90-C $20	80-G $20	80-L $30
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0	$200/$500	$500/$1,000	$2,000/$4,000
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$4,000/$8,000
PROFESSIONAL SERVICES				
Office Visit (OV) co-pay ($0 Copay for first 3 calendar year Primary Care office visits on Non-HSA PPO plans)	$20	$20	$20	$30
Urgent Care co-pay	$20	$20	$20	$30
Specialists/Consultants co-pay	$20	$20	$20	$30
Prenatal, postnatal office visit co-pay	$20	$20	$20	$30
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	20%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	20%
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (waived if admitted)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	20%	20%
Outpatient Hospital	0%	10%	20%	20%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	20%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	20%	20%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT				
INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	20%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	20%
OTHER SERVICES				
Acupuncture - Limits apply	0%	10%	20%	20%
Ambulance (Ground or Air)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay
Chiropractic - Limits apply	0%	10%	20%	20%
Durable Medical Equipment (DME)	0%	10%	20%	20%
Physical and Occupational Therapy - Limits apply	0%	10%	20%	20%
Hearing Aids	Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months
PHARMACY BENEFITS				
Plan	**9-35**	**9-35**	**9-35**	**9-35**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500
Generic co-pay/30 days supply	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network
Brand co-pay/30 days supply	$35	$35	$35	$35
Specialty co-pay/up to 30 days supply	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$90	$0-$90	$0-$90	$0-$90
Mail Order Pharmacy	Costco 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