

**CMSA**

2020-2021	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Kaiser	Kaiser
	100-A \$20	100-C \$20	90-C \$20	80-G \$30	Anchor Bronze (HSA Compatible)	Trad HMO \$10	Trad HMO \$30
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$200/\$400	\$200/\$500	\$500/\$1,000	\$5,000/\$10,000*	\$0	\$0
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$4,000	\$6,350/\$12,700*	\$1,500/\$3,000	\$1,500/\$3,000

**PROFESSIONAL SERVICES** \*Includes Rx

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	Deductible, then 30%	\$10	\$30
Urgent Care co-pay	\$20	\$20	\$20	\$30	30%	\$10	\$30
Specialists/Consultants co-pay	\$20	\$20	\$20	\$30	30%	\$10	\$30
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$30	30%	\$0	\$0
Scans: CT, CAT, MRI, PET etc.	0%	0%	10%	20%	30%	\$0	\$0
Diagnostic X-ray & Laboratory Procedures	0%	0%	10%	20%	30%	\$0	\$0
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered	Not covered	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

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

Emergency Room visit (waived if admitted)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$100	\$100
Inpatient Hospital (preauthorization required) - limits may apply	0%	0%	10%	20%	30%	\$0	\$0
Outpatient Hospital	0%	0%	10%	20%	30%	\$10	\$30
Surgery, Outpatient (performed in Surgery Center)	0%	0%	10%	20%	30%	\$10	\$30
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	0%	10%	20%	30%	\$10	\$30

**MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT**

<b>INPATIENT:</b> Facility Based Care (preauth required)	0%	0%	10%	20%	30%	\$0	\$0
<b>OUTPATIENT:</b> Facility Based Care (preauth required)	0%	0%	10%	20%	30%	\$10	\$30

**OTHER SERVICES**

Acupuncture - Limits apply	0%	0%	10%	20%	30%	\$10/30 visits combined w/chiro	\$10/30 visits combined w/chiro
Ambulance (Ground or Air)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$50	\$50
Chiropractic - Limits apply	0%	0%	10%	20%	30%	\$10/30 visits combined w/acu	\$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	0%	10%	20%	30%	no charge	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	10%	20%	30%	\$10	\$30
Hearing Aids	Amount in excess of \$700 allowance/24 months	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	30% and Amount in excess of \$700 allowance/24 months	amount in excess of \$500 allowance every 36 months	amount in excess of \$500 allowance every 36 months

**PHARMACY BENEFITS**

Plan	7-25	200/10-35	9-35	9-35	Anchor Bronze Rx	Trad HMO \$10	Trad HMO \$30
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	\$200/\$500	none	none	Included w/ Medical ded	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$1,500/\$2,500	\$2,500/\$3,500	\$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 \$7 at Other Network	\$0 at Costco \$10 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network	\$10 up to 100 day supply	\$10 up to 100 day supply
Brand co-pay/30 days supply	\$25	\$35	\$35	\$35	Deductible, then \$35	\$10 up to 100 day supply	\$30 up to 100 day supply
Specialty co-pay/up to 30 days supply	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	\$10 up to 30 day supply	\$30 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60	\$0-\$90	\$0-\$90	\$0-\$90	Deductible, then \$18-\$90	\$10-\$10/up to 100 day supply	\$10-\$30/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	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.