



District Name Coast Unified School District

Bargaining Unit Classified

2016-2017	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem
	90-A \$20	90-C \$30	80-E \$20	80-G \$30	Minimum Value	Select Medical Plan	Select Medical Plan
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$100/ \$300	\$200/ \$500	\$300/ \$600	\$500/ \$1,000	\$5,000/ \$10,000*		
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	\$1,000/ \$3,000	\$1,000/ \$3,000	\$1,000/ \$3,000	\$2,000/ \$4,000	\$6,350/ \$12,700*		

*Includes Rx

PROFESSIONAL SERVICES

Office Visit (OV) co-pay	\$20	\$30	\$20	\$30	\$60 visits 1-3, then 30% after ded		
Urgent Care co-pay	\$20	\$30	\$20	\$30	\$60 visits 1-3, then 30% after ded		
Specialists/Consultants co-pay	\$20	\$30	\$20	\$30	\$60 visits 1-3, then 30% after ded		
Prenatal, postnatal office visit co-pay	\$20	\$30	\$20	\$30	\$60 visits 1-3, then 30% after ded		
Scans: CT, CAT, MRI, PET etc.	10%	10%	20%	20%	30%		
Diagnostic X-ray & Laboratory Procedures	10%	10%	20%	20%	30%		
Infertility (diagnosis/treatment of causes of infertility)	Not covered	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	0% Ded Waived		

HOSPITAL & SKILLED NURSING FACILITY SERVICES

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

	90-A \$20	90-C \$30	80-E \$20	80-G \$30	Minimum Value	Select Medical Plan	Select Medical Plan
--	-----------	-----------	-----------	-----------	---------------	---------------------	---------------------

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	10%	10%	20%	20%	30%		
OUTPATIENT: Facility Based Care (preauth required)	10%	10%	20%	20%	30%		

OTHER SERVICES

Acupuncture - Limits apply	10%	10%	20%	20%	30%		
Ambulance (Ground or Air)	10%	10%	20%	20%	30%		
Chiropractic - Limits apply	10%	10%	20%	20%	30%		
Durable Medical Equipment (DME)	10%	10%	20%	20%	30%		
Physical and Occupational Therapy - Limits apply	10%	10%	20%	20%	30%		

PHARMACY BENEFITS

Plan	200/10-35	9-35	200/10-35	200/10-35	Minimum Value Rx	Select Rx Plan	Select Rx Plan
Individual/Family Brand & Specialty Rx Deductibles	\$200/\$500	none	\$200/\$500	\$200/\$500	Included w/ Medical ded		
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	Included w/ Med OOP Max		
Generic co-pay/30 days supply	\$0 at Costco \$10 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$10 at Other Network	\$0 at Costco \$10 at Other Network	\$9		
Brand co-pay/30 days supply	\$35	\$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 \$35		
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$90	\$18-\$90		