

Sebastopol Charter

Bargaining Unit

2022-2023	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield
	100-B \$20	90-E \$20 (Non-Marketed)	80-G \$20	HSA-B	Anchor Bronze (HSA Compatible)
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$100/\$300	\$300/\$600	\$500/\$1,000	\$3,000/\$5,200*	\$5,000/\$10,000*
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	\$2,000/\$4,000	\$5,000/\$10,000*	\$6,350/\$12,700*

*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)	\$20	\$20	\$20	Deductible, then 10%	Deductible, then 30%
Urgent Care co-pay	\$20	\$20	\$20	10%	30%
Specialists/Consultants co-pay	\$20	\$20	\$20	10%	30%
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	10%	30%
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	10%	30%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	10%	30%
Infertility (Refer to Plan Document)	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 (copay waived if admitted)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	10% \$100 co-pay	30% \$100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	20%	10%	30%
Outpatient Hospital	0%	10%	20%	10%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	10%	30%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	20%	10%	30%

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%	30%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%	30%

OTHER SERVICES

Ambulance (Ground or Air)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	10% \$100 co-pay	30% \$100 co-pay
Acupuncture - Limits apply	0%	10%	20%	10%	30%
Chiropractic - Limits apply	0%	10%	20%	10%	30%
Durable Medical Equipment (DME)	0%	10%	20%	10%	30%
Physical and Occupational Therapy - Limits apply	0%	10%	20%	10%	30%
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	10% and Amount in excess of \$700 allowance/24 months	30% and Amount in excess of \$700 allowance/24 months

PHARMACY BENEFITS

Plan	7-25	7-25	9-35	Select Rx Plan	Minimum Value Rx
Pharmacy Benefit Manager	Navitus	Navitus	Navitus		Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none		Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$1,500/\$2,500	\$1,500/\$2,500	\$2,500/\$3,500		Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$7 at Other Network	\$0 at Costco \$7 at Other Network	\$0 at Costco \$9 at Other Network		Deductible, then \$0 at Costco or \$9 at Other Network
Brand co-pay/30 days supply	\$25	\$25.00	\$35.00		Deductible, then \$35
Specialty co-pay/up to 30 days supply	\$25 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail		Deductible, then \$35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60	\$0-\$60	\$0-\$90		Deductible, then \$18-\$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 from the district.