

Plan Type (PPO or HMO) Carrier (Anthem Blue Cross, Blue Shield, or Kaiser)	PPO Anthem	PPO Anthem	PPO Anthem	HMO Kaiser	HMO Kaiser	HMO Kaiser
District Name Bargaining Unit	Marin CCD					
2023-2024	Anthem	Anthem	Anthem	Kaiser	Kaiser	Kaiser
	100-A \$20	80-K \$30	HSA \$1500 - Family	Trad HMO \$20	Ded HMO \$1,000	HSA-\$1500 Family
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$1,000/\$2,000	\$3,000/\$3,000*	\$0	\$1,000/	\$3,000/ \$3,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	\$1,000/\$3,000	\$3,000/\$6,000	\$3,000/\$6,000*	\$1,500/\$3,000	\$3,000/\$6,000	\$3,000/\$6,000*

*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	\$30	Deductible, then 10%	\$20	\$20	Deductible, then 10%
Urgent Care co-pay	\$20	\$30	10%	\$20	\$20	10%
Specialists/Consultants co-pay	\$20	\$30	10%	\$20	\$20	10%
Prenatal, postnatal office visit co-pay	\$20	\$30	10%	\$0	\$0	\$0
Scans: CT, CAT, MRI, PET etc.	0%	20%	10%	\$0	20% Copay	10%
Diagnostic X-ray & Laboratory Procedures	0%	20%	10%	\$0	\$10	10%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Co-pay applies	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	0%	0%	0%	\$0	0%	0%
	Ded Waived	Ded Waived	Ded Waived		Ded Waived	Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

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

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

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

OTHER SERVICES

Ambulance (Ground or Air)	0%	20%	10%	\$50	\$150	10%
Acupuncture - Limits apply	0% Uses ASH Network	20% Uses ASH Network	10% Uses ASH Network	\$10/30 visits (through ASH) combined w/chiro	\$10/30 visits (through ASH) combined w/chiro	Requires Prior Authorization
Chiropractic - Limits apply	0% Uses ASH Network	20% Uses ASH Network	10% Uses ASH Network	\$10/30 visits (through ASH) combined w/acu	\$10/30 visits (through ASH) combined w/acu	no coverage
Durable Medical Equipment (DME)	0%	20%	10%	no charge	20%	10%
Physical and Occupational Therapy - Limits apply	0%	20%	10%	\$20	\$20	10%
Hearing Aids	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	amount in excess of \$500 allowance every 36 months	amount in excess of \$500 allowance every 36 months	no coverage

PHARMACY BENEFITS

Plan	5-20	9-35	HSA Rx	Trad HMO \$20	Ded HMO \$1,000	HSA A
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Kaiser	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	Included w/ Medical ded	none	none	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$1,500/\$2,500	\$2,500/\$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$5 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	\$10.00	deductible, then \$10
Brand co-pay/30 days supply	\$20	\$35.00	Deductible, then \$35	\$20 up to 100 day supply	\$30.00	deductible, then \$30
Specialty co-pay/up to 30 days supply	\$20 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	\$20 up to 30 day supply	\$30.00	deductible, then \$30
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$50	\$0-\$90	Deductible, then \$0-\$90	\$10-\$20/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	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 applicable, can be requested from the district.

*Coverage stages apply, see benefit summary for details