

ECS Classified Members
October 1, 2021 - September 30, 2022

	PLAN A	PLAN B	PLAN C	PLAN D	PLAN F	PLAN E	Anchor
2021-2022	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem
	100-D \$20	90-G \$20	80-G \$20	80-K \$30	80-M \$40	Minimum Value (HSA Compatible)	Anchor Bronze (HSA Compatible)
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$300/\$600	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$3,000/\$6,000	\$5,000/\$10,000*	\$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	\$2,000/\$4,000	\$3,000/\$6,000	\$4,000/\$8,000	\$6,350/\$12,700*	\$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	\$30	\$40	Deductible, then 30%	Deductible, then 30%
Urgent Care co-pay	\$20	\$20	\$20	\$30	\$40	30%	30%
Specialists/Consultants co-pay	\$20	\$20	\$20	\$30	\$40	30%	30%
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$30	\$40	30%	30%
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	20%	20%	30%	30%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	20%	20%	30%	30%
Infertility (Refer to Plan Document)	Not covered	Not covered	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	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	20% \$100 co-pay	30% \$100 co-pay	30% \$100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	20%	20%	20%	30%	30%
Outpatient Hospital	0%	10%	20%	20%	20%	30%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	20%	20%	30%	30%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	20%	20%	20%	30%	30%

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

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

OTHER SERVICES

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

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PHARMACY BENEFITS

Plan	200/10-35	200/10-35	9-35	200/10-35	200/10-35	Minimum Value Rx	Anchor Bronze Rx
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	\$200/\$500	\$200/\$500	none	\$200/\$500	\$200/\$500	Included w/ Medical ded	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	\$2,500/\$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$10 at Other Network	\$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	Deductible, then \$0 at Costco or \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network
Brand co-pay/30 days supply	\$35	\$35.00	\$35.00	\$35.00	\$35.00	Deductible, then \$35	Deductible, then \$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	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	Deductible, then \$35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$90	Deductible, then \$0-\$90	Deductible, then \$0-\$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco 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.