

**District Name** Cuesta College  
**Bargaining Unit** CCFT

2023-2024	Anthem	Anthem	Anthem
	80-E \$20	80-G \$30	80-L \$30
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
Individual/Family Deductibles	\$300/\$600	\$500/\$1,000	\$2,000/\$4,000
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	\$1,000/\$3,000	\$2,000/\$4,000	\$4,000/\$8,000

**PROFESSIONAL SERVICES**

Office Visit (OV) co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$20	\$30	\$30
Urgent Care co-pay	\$20	\$30	\$30
Specialists/Consultants co-pay	\$20	\$30	\$30
Prenatal, postnatal office visit co-pay	\$20	\$30	\$30
Scans: CT, CAT, MRI, PET etc.	20%	20%	20%
Diagnostic X-ray & Laboratory Procedures	20%	20%	20%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

Emergency Room visit (copay waived if admitted)	20% \$100 co-pay	20% \$100 co-pay	20% \$100 co-pay
Inpatient Hospital (preauthorization required) limits may apply	20%	20%	20%
Outpatient Hospital	20%	20%	20%

Surgery, Outpatient (performed in Surgery Center)	20%	20%	20%
Surgery, Outpatient (performed in a Hospital) - limits may apply	20%	20%	20%

#### MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

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

#### OTHER SERVICES

Ambulance (Ground or Air)	20% \$100 co-pay	20% \$100 co-pay	20% \$100 co-pay
Acupuncture - Limits apply	20% Uses ASH Network	20% Uses ASH Network	20% Uses ASH Network
Chiropractic - Limits apply	20% Uses ASH Network	20% Uses ASH Network	20% Uses ASH Network
Durable Medical Equipment (DME)	20%	20%	20%
Physical and Occupational Therapy - Limits apply	20%	20%	20%
Hearing Aids	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

#### PHARMACY BENEFITS

Plan	7-25	200/10-35	200/10-35
Pharmacy Benefit Manager	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	\$200/\$500	\$200/\$500
Individual/Family Rx Out-of- Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$1,500/\$2,500	\$2,500/\$3,500	\$2,500/\$3,500

Generic co-pay/30 days supply	\$0 at Costco \$7 at Other Network	\$0 at Costco \$10 at Other Network	\$0 at Costco \$10 at Other Network
Brand co-pay/30 days supply	25	35	35
Specialty co-pay/up to 30 days supply	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60	\$0-\$90	\$0-\$90
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 document and exclusions. Out-of-Network services may not be covered. Employee cost/payroll d

\*Coverage stages apply, see benefit summary for details

<b>Anthem</b>	<b>Anthem</b>	<b>Anthem</b>
<b>80-M \$40</b>	<b>HSA-\$3000</b>	<b>Two-Tier HSA \$5000 (Formerly Anchor Bronze)</b>
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
\$3,000/\$6,000	\$3,000/\$5,200*	\$5,000/\$10,000*
\$4,000/\$8,000	\$5,000/\$10,000*	\$6,350/\$12,700*

\*Includes Rx

\*Includes Rx

\$40	Deductible, then 10%	Deductible, then 30%
\$40	10%	30%
\$40	10%	30%
\$40	10%	30%
20%	10%	30%
20%	10%	30%
Not covered	Not covered	Not covered
0% Ded Waived	0% Ded Waived	0% Ded Waived

20% \$100 co-pay	10% \$100 co-pay	30% \$100 co-pay
20%	10%	30%
20%	10%	30%

20%	10%	30%
20%	10%	30%

20%	10%	30%
20%	10%	30%

20% \$100 co-pay	10% \$100 co-pay	30% \$100 co-pay
20% Uses ASH Network	10% Uses ASH Network	30% Uses ASH Network
20% Uses ASH Network	10% Uses ASH Network	30% Uses ASH Network
20%	10%	30%
0.2	10%	30%
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

9-35	HSA-B Rx	Two-Tier HSA \$5000
Navitus	Navitus	Navitus
none	Included w/ Medical ded	Included w/ Medical ded
\$2,500/\$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max

\$0 at Costco \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network
35	Deductible, then \$35	Deductible, then \$35
\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	Deductible, then \$35 (Must Use Navitus Mail)
\$0-\$90	Deductible, then \$0- \$90	Deductible, then \$0- \$90
Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

nts available through your district for applicable details, limitations,  
education, if applicable, can be requested from the district.