SISC
Self-Insured Schools of California
Schools Helping Schools

ECS Certificated Members
October 1, 2024 - September 30, 2025

2024-2025	PLAN A Anthem 100-D $20	PLAN B Anthem 100-G $20	PLAN C Anthem 90-G $20	PLAN D Anthem 80-G $20	PLAN E Anthem 80-J $30	PLAN F Anthem HSA $5000 (Formerly Minimum Value)	HSA $5000 Anthem Two-Tier HSA $5000 (Formerly Anchor Bronze)
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	$500/$1,000	$750/$1,500	$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	$1,000/$3,000	$2,000/$4,000	$3,000/$6,000	$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	$20	$30	Deductible, then 30%	Deductible, then 30%
Urgent Care co-pay	$20	$20	$20	$20	$30	30%	30%
Specialists/Consultants co-pay	$20	$20	$20	$20	$30	30%	30%
Prenatal, postnatal office visit co-pay	$20	$20	$20	$20	$30	30%	30%
Scans: CT, CAT, MRI, PET etc.	0%	0%	10%	20%	20%	30%	30%
Diagnostic X-ray & Laboratory Procedures	0%	0%	10%	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 (copay waived if admitted)	0% $100 co-pay	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay
Inpatient Hospital (preauth. required) - limits may apply	0%	0%	10%	20%	20%	30%	30%
Outpatient Hospital	0%	0%	10%	20%	20%	30%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	0%	10%	20%	20%	30%	30%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	0%	10%	20%	20%	30%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT							
INPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	20%	30%	30%
OUTPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	20%	30%	30%

SISC
Self-Insured Schools of California
Schools Helping Schools

ECS Certificated Members
October 1, 2024 - September 30, 2025

2024-2025	PLAN A Anthem 100-D $20	PLAN B Anthem 100-G $20	PLAN C Anthem 90-G $20	PLAN D Anthem 80-G $20	PLAN E Anthem 80-J $30	PLAN F Anthem HSA $5000 (Formerly Minimum Value)	HSA $5000 Anthem Two-Tier HSA $5000 (Formerly Anchor Bronze)
OTHER SERVICES							
Ambulance (Ground or Air)	0% $100 co-pay	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay
Acupuncture - Limits apply	0% Uses ASH Network	0% Uses ASH Network	10% Uses ASH Network	20% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network
Chiropractic - Limits apply	0% Uses ASH Network	0% Uses ASH Network	10% Uses ASH Network	20% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	30% Uses ASH Network
Durable Medical Equipment (DME)	0%	0%	10%	20%	20%	30%	30%
Physical and Occupational Therapy - Limits apply	0%	0%	10%	20%	20%	30%	30%
Hearing Aids	Amount in excess of $700 allowance/24 months	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	10% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months
PHARMACY BENEFITS							
Plan	**200/10-35**	**200/10-35**	**200/10-35**	**200/10-35**	**200/10-35**	**HSA Rx**	**HSA Rx**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	$200/$500	$200/$500	$200/$500	$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 $10 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.

*Coverage stages apply, see benefit summary for details