Salinas City Elementary School District
Anthem PPO & HDHP
CVT Proposal Effective: January 1, 2026

Medical Plan Benefits	CVT Anthem PPO 10, Rx V Option		CVT Anthem PPO HDHP 1 Option		CVT Anthem PPO Bronze Option		CVT Anthem PPO HDHP 3 Option	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible Individual / Individual within Family / Family	$2,000 / $4,000		$1,700 / $3,400		$5,000 / $10,000		$6,500 / $13,000	
Annual Out-of-Pocket Maximum Individual / Individual within Family / Family	$6,350 / $12,700		$5,000 / $10,000		$7,000 / $14,000		$8,000 / $16,000	
Coinsurance	20%	20% after deductible; All billed amounts exceeding the max allowed amount	10%	10% after deductible; All billed amounts exceeding the max allowed amount	30%	30% after deductible; All billed amounts exceeding the max allowed amount	30%	30% after deductible; All billed amounts exceeding the max allowed amount
Physician Office Visit	20%	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	$60 first 3 visits, 30% after	30% after deductible; All billed amounts exceeding the max allowed amount	$60	30% after deductible; All billed amounts exceeding the max allowed amount
Specialist Visit	20%		10% after deductible is met		$60 first 3 visits, 30% after		$90	
Preventive Care	No Charge*		No Charge*		No Charge*		No Charge*	
Lab- Freestanding Facility / OP Hospital	Non-Hospital: 20% after deductible Hospital: $50 + 20% after deductible	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible	30% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible is met	30% after deductible; All billed amounts exceeding the max allowed amount
X-Rays- Freestanding Facility / OP Hospital	Non-Hospital: 20% after deductible Hospital: $75 + 20% after deductible		10% after deductible is met		30% after deductible		30% after deductible is met	
Advanced Imaging- CT, MRI, PET scans	Non-Hospital: 20% after deductible Hospital: $75 + 20% after deductible		10% after deductible is met		30% after deductible		30% after deductible is met	
Urgent Care Services	20%	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	$120 after deductible	30% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible is met	30% after deductible; All billed amounts exceeding the max allowed amount
Emergency Room	$150 + 20% (copay waived if admitted)		10% after deductible is met		$250 (copay waived if admitted)		30% after deductible is met	
Ambulatory Surgical Center	20% after deductible	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible	30% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible is met	30% after deductible; All billed amounts exceeding the max allowed amount
Outpatient Surgery	Non-Hospital: 20% after deductible Hospital: $250 + 20% after deductible		10% after deductible is met		30% after deductible		30% after deductible is met	
Inpatient Hospitalization	20% after deductible		10% after deductible is met		30% after deductible		30% after deductible is met	
Chiropractic Care	20% after deductible	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible	30% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible is met	30% after deductible; All billed amounts exceeding the max allowed amount
Visits per Calendar Year								
Acupuncture Care	20% after deductible	20% after deductible; All billed amounts exceeding the max allowed amount	10% after deductible is met	10% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible	30% after deductible; All billed amounts exceeding the max allowed amount	30% after deductible is met	30% after deductible; All billed amounts exceeding the max allowed amount
Visits per Calendar Year	*(Maximum of 12 visits per calendar year))*		*(Maximum of 12 visits per calendar year))*		*(Maximum of 12 visits per calendar year))*		*(Maximum of 12 visits per calendar year))*	
PRESCRIPTION DRUGS								
Prescription Deductible	$150		Combined with Medical OOPM		None		Combined with Medical OOPM	
Prescription Out-of-Pocket Maximum	N/A		Combined with Medical OOPM		N/A		Combined with Medical OOPM	
Pharmacy Tier Structure	Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary	
Retail Cost	$0 / $30	20% after deductible; All billed amounts exceeding the max allowed amount	$25 / $50 (after deductible)	10% after deductible; All billed amounts exceeding the max allowed amount	$25 / $50 (after deductible)	30% after deductible; All billed amounts exceeding the max allowed amount	$25 / $50 (after deductible)	30% after deductible; All billed amounts exceeding the max allowed amount
Supply Limit	*30 days supply*	*N/A*	*30 days supply*	*N/A*	*30 days supply*	*N/A*	*30 days supply*	*N/A*
Mail Order Cost	$0 / $60	20% after deductible; All billed amounts exceeding the max allowed amount	$50 / $100 (after deductible)	10% after deductible; All billed amounts exceeding the max allowed amount	$50 / $100 (after deductible)	30% after deductible; All billed amounts exceeding the max allowed amount	$50 / $100 (after deductible)	30% after deductible; All billed amounts exceeding the max allowed amount
Supply Limit	*90 days*	*N/A*	*90 days*	*N/A*	*90 days*	*N/A*	*90 days*	*N/A*
Specialty Medication Cost	If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for specialty medications will be $0. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for your specialty medications.	Not Covered	If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for specialty medications will be $0. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for your specialty medications.	Not Covered	If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for specialty medications will be $0. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for your specialty medications.	Not Covered	If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for specialty medications will be $0. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for your specialty medications.	Not Covered
Network	Full Network		Full Network		Full Network		Full Network	

MONTHLY RATES - Actives	CVT Anthem PPO 10, Rx V	CVT Anthem PPO HDHP 1	CVT Anthem PPO Bronze	CVT Anthem PPO HDHP 3
EE Only	$1,540.00	$1,579.00	$1,286.00	$1,185.00
EE + 1	$2,649.00	$2,716.00	$2,213.00	$2,039.00
EE + Family	$3,341.00	$3,426.00	$2,792.00	$2,571.00

* Deductible does not apply.

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.