

**District Name Marin County Office of Education**  
**Bargaining Unit All Bargaining Units**

| 2022-2023  | Anthem          | Anthem          | Anthem            | Kaiser          | Kaiser              | Kaiser       | Kaiser            |
|--|-----------------|-----------------|-------------------|-----------------|---------------------|--------------|-------------------|
|  | 100-B \$20      | 80-G \$30       | HSA-B             | Trad HMO \$15   | Ded HMO \$1,000     | HSA-A Single | HSA-A Family      |
| <b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>  | Member Pays     | Member Pays     | Member Pays       | Member Pays     | Member Pays         | Member Pays  | Member Pays       |
| Individual/Family Deductibles  | \$100/\$300     | \$500/\$1,000   | \$3,000/\$5,200*  | \$0             | \$1,000/<br>\$2,000 | \$1,500*     | \$2,800/ \$3,000* |
| Individual/Family Out-of-Pocket (OOP) Max<br><i>(includes medical deductibles, co-insurance and co-pays)</i> | \$1,000/\$3,000 | \$2,000/\$4,000 | \$5,000/\$10,000* | \$1,500/\$3,000 | \$3,000/\$6,000     | \$3,000*     | \$3,000/\$6,000*  |

\*Includes Rx

\*Includes Rx

\*Includes Rx

**PROFESSIONAL SERVICES**

|   |             |             |                      |                |                |                      |                      |
|---|-------------|-------------|----------------------|----------------|----------------|----------------------|----------------------|
| Office Visit (OV) co-pay <i>(\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)</i> | \$20        | \$30        | Deductible, then 10% | \$15           | \$20           | Deductible, then 10% | Deductible, then 10% |
| Urgent Care co-pay  | \$20        | \$30        | 10%                  | \$15           | \$20           | 10%                  | 10%                  |
| Specialists/Consultants co-pay  | \$20        | \$30        | 10%                  | \$15           | \$20           | 10%                  | 10%                  |
| Prenatal, postnatal office visit co-pay   | \$20        | \$30        | 10%                  | \$0            | \$0            | \$0                  | \$0                  |
| Scans: CT, CAT, MRI, PET etc.   | 0%          | 20%         | 10%                  | \$0            | 20% Copay      | 10%                  | 10%                  |
| Diagnostic X-ray & Laboratory Procedures  | 0%          | 20%         | 10%                  | \$0            | \$10           | 10%                  | 10%                  |
| Infertility (Refer to Plan Document)  | Not covered | Not covered | Not covered          | Co-pay applies | Co-pay applies | Co-pay applies       | Co-pay applies       |
| Preventive Care (includes physical exams & screenings)  | 0%          | 0%          | 0%                   | \$0            | 0%             | 0%                   | 0%                   |
|   | Ded Waived  | Ded Waived  | Ded Waived           | Ded Waived     | Ded Waived     | Ded Waived           | Ded Waived           |

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

|   |                    |                     |                     |       |     |     |     |
|---|--------------------|---------------------|---------------------|-------|-----|-----|-----|
| Emergency Room visit<br><i>(copay waived if admitted)</i>         | 0%<br>\$100 co-pay | 20%<br>\$100 co-pay | 10%<br>\$100 co-pay | \$100 | 20% | 10% | 10% |
| Inpatient Hospital (preauthorization required) - limits may apply | 0%                 | 20%                 | 10%                 | \$0   | 20% | 10% | 10% |
| Outpatient Hospital   | 0%                 | 20%                 | 10%                 | \$15  | 20% | 10% | 10% |
| Surgery, Outpatient (performed in Surgery Center)                 | 0%                 | 20%                 | 10%                 | \$15  | 20% | 10% | 10% |
| Surgery, Outpatient (performed in a Hospital) - limits may apply  | 0%                 | 20%                 | 10%                 | \$15  | 20% | 10% | 10% |

**MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT**

|   |    |     |     |      |     |     |     |
|---|----|-----|-----|------|-----|-----|-----|
| <b>INPATIENT:</b> Facility Based Care (preauth required)  | 0% | 20% | 10% | \$0  | 20% | 10% | 10% |
| <b>OUTPATIENT:</b> Facility Based Care (preauth required) | 0% | 20% | 10% | \$15 | 20% | 10% | 10% |

**OTHER SERVICES**

|  |   |   |   |   |   |                              |                              |
|--|---|---|---|---|---|------------------------------|------------------------------|
| Ambulance (Ground or Air)                        | 0%<br>\$100 co-pay                            | 20%<br>\$100 co-pay                                   | 10%<br>\$100 co-pay                                   | \$50  | \$150   | 10%                          | 10%                          |
| Acupuncture - Limits apply                       | 0%<br>Uses ASH Network                        | 20%<br>Uses ASH Network                               | 10%<br>Uses ASH Network                               | \$10/30 visits (through ASH) combined w/chiro       | \$10/30 visits (through ASH) combined w/chiro       | Requires Prior Authorization | Requires Prior Authorization |
| Chiropractic - Limits apply                      | 0%<br>Uses ASH Network                        | 20%<br>Uses ASH Network                               | 10%<br>Uses ASH Network                               | \$10/30 visits (through ASH) combined w/acu         | \$10/30 visits (through ASH) combined w/acu         | no coverage                  | no coverage                  |
| Durable Medical Equipment (DME)                  | 0%  | 20%   | 10%   | no charge   | 20%   | 10%                          | 10%                          |
| Physical and Occupational Therapy - Limits apply | 0%  | 20%   | 10%   | \$15  | \$20  | 10%                          | 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                  | no coverage                  |

**PHARMACY BENEFITS**

| Plan   | 9-35                                  | 9-35                                  | HSA-B Rx   | Custom \$5-\$20 (30 day)       | Ded HMO \$1,000                | HSA A                          | HSA A                          |
|--|---------------------------------------|---------------------------------------|--|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Pharmacy Benefit Manager   | Navitus                               | Navitus                               | Navitus  | Kaiser                         | Kaiser                         | Kaiser                         | Kaiser                         |
| Individual/Family Brand & Specialty Rx Deductibles   | none                                  | none                                  | Included w/ Medical ded                                | none                           | none                           | Included w/ Medical ded        | Included w/ Medical ded        |
| Individual/Family Rx Out-of-Pocket (OOP) Max<br><i>(includes Rx deductibles and co-pays)</i> | \$2,500/\$3,500                       | \$2,500/\$3,500                       | Included w/ Med OOP Max                                | Included w/ Med OOP Max        | Included w/ Med OOP Max        | Included w/ Med OOP Max        | Included w/ Med OOP Max        |
| Generic co-pay/30 days supply  | \$0 at Costco<br>\$9 at Other Network | \$0 at Costco<br>\$9 at Other Network | Deductible, then \$0 at Costco or \$9 at Other Network | \$5 up to 30 day supply        | \$10.00                        | deductible, then \$10          | deductible, then \$10          |
| Brand co-pay/30 days supply  | \$35                                  | \$35.00                               | Deductible, then \$35                                  | \$20 up to 30 day supply       | \$30.00                        | deductible, then \$30          | deductible, then \$30          |
| Specialty co-pay/up to 30 days supply  | \$35 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          | deductible, then \$30          |
| Mail Order (Generic-Brand co-pay/90 days supply)   | \$0-\$90                              | \$0-\$90                              | Deductible, then \$0-\$90                              | \$10-\$40/up to 100 day supply | \$20-\$60/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     | 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.