

Anthem Medical Plan Menu



NOTE: Your district/bargaining unit may not offer all plans listed below. Contact your district's HR/Payroll department for more information.
 This is only a brief overview of your plan's benefits. For more detailed information about the benefits in your plan, please refer to your Evidence of Coverage (EOC).

	80% G \$30	80% J \$30	80% L \$30	80% M \$40	HSA \$1700 ²	HSA \$5000 ²	MEC \$9000
Active EE w/ Deps	\$2,119	\$1,925	\$1,750	\$1,573	\$1,826	\$1,305	\$1,234
Active EE 2X Discount	-\$530	-\$481	-\$438	-\$393	-\$457	-\$326	-\$309
MEDICAL							
Calendar Year Out-of-Pocket Max ¹ Individual / Family	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$8,000	\$4,000 / \$8,000	\$3,400 / \$6,800	\$6,350 / \$12,700	\$9,000 / \$18,000
Calendar Year Deductible Individual / Family	\$500 / \$1,000	\$750 / \$1,500	\$2,000 / \$4,000	\$3,000 / \$6,000	\$1,700 Single \$3,400 Ind / Fam	\$5,000 / \$10,000	\$9,000 / \$18,000
4 th Q Carryover	Yes				No		
Office Visits							
HWC	\$0				\$25		
Other Providers ³	\$30	\$30	\$30	\$40	10% after deductible	30% after deductible	0% after deductible
MDLive Virtual Visit	\$0				~ \$50 - \$75, applied to deductible		
Preventive Exam	\$0				\$0		
Diagnostic Services							
Labs	20% after deductible				10% after deductible	30% after deductible	0% after deductible
X-rays / Advanced Imaging	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Therapeutic Services							
Physical or Occupational Chiropractic	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Facility Services							
Emergency Room ⁴	20% after deductible + \$100				10% after deductible + \$100	30% after deductible + \$100	0% after deductible + \$100
Outpatient Surgery ⁵	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Office Visit (Hospital Facility)	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Hospitalization	20% after deductible				10% after deductible	30% after deductible	0% after deductible
PRESCRIPTION							
Out-of-Pocket Maximum ¹	\$2,500 / \$3,500				Combined with Medical		
Deductible (Brand, only)	\$200 / \$500				Combined with Medical		
Costco (Retail or Mail)	Up to 90-day supply: \$0 generic / \$90 brand after deductible				\$0 generic / \$90 brand after deductible		
Other Retail Pharmacy	Up to 30-day supply: \$10 generic / \$35 brand after deductible				\$9 generic / \$35 brand after deductible		
Specialty	Up to 30-day supply: \$35 after deductible				Up to 30-day supply: \$35 after deductible		

¹Plans have a separate Out-of-pocket (OOP) maximum for both medical and prescription for non-HSA plans. Generally, non-network claims do not apply to limits.

²HSA compliant plans are subject to legislative and regulation changes throughout the year.

³\$0 for first three primary care office visits

⁴\$100 copay waived if admitted.

⁵See Benefits Restrictions & Limitations

Dental



Regular visits to your dentist protect more than your smile; they protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. Butte Schools Self-Funded Programs provides you with comprehensive coverage through Delta Dental of California. Your employer will provide you with separate information about the amount the district will contribute towards your plan's monthly rate.

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	Plan 1	Plan 8	Plan 10	Plan 12
Monthly Rate	\$69	\$115	\$124	\$145
Network	PPO Only	PPO + Premier		
Calendar Year Plan Maximum	\$1,200/individual PPO \$1,000/individual non-network <i>Diagnostic and Preventive Services do not count toward the Calendar Year Plan Maximum</i>	\$2,200/individual PPO \$2,000/individual Premier & non-network		\$3,000/individual PPO & Premier \$2,000/individual non-network
Calendar Year Deductible	\$50 / individual \$150 / family	\$0 / individual \$0 / family		
Cleanings	3 per calendar year			
Diagnostic & Preventive	Plan pays 100%	Plan pays 70% - 100%		
Basic Services Fillings Root Canals Periodontics	Plan pays 80%	Plan pays 70%-100%		
Major Services	Plan pays 50%	Plan pays 70%-100% (prosthodontics are 50%)		
Orthodontic Services	Not covered		Plan pays 100% Up to \$2,000 lifetime	Plan pays 100% Up to \$2,500 lifetime
Occlusal Night Guard	Plan pays 50% up to \$750 lifetime			

Vision



Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. Your employer will provide you with separate information about the amount the district will contribute towards your plan's monthly rate.

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	Plan 4	Plan 4X	Plan 8	Plan 8X
Monthly Rate	\$19	\$32	\$29	\$42
Examination Benefit	\$10 copay then plan pays 100%			
Frequency (last service date)	1 x every 12 months			
Materials	\$10 copay then plan pays 100%			
Eyeglass Lenses	Basic lens combined with exam			
Single Vision				
Bifocal				
Trifocal				
Enhancements				
Tints/Light-reactive lenses/UV protection/Standard progressive lenses	\$0			
Premium and Custom progressive lenses	\$40			
Anti-glare coating	\$40			
Frequency (last service date)	1 x every 12 months			
Frames Benefit	\$270 featured frame brands allowance \$250 frame allowance 20% savings on the amount over your allowance \$135 Costco®/Walmart®/Sam's Club® frame allowance			
LIGHTCARE™	\$250 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts			
Frequency (last service date)	1 x every 24 months	1 x every 24 months	1 x every 12 months	1 x every 12 months
Contacts (Elective) Benefit	\$250 allowance (copay waived; instead of eyeglasses)	\$50 copay for fitting exam and annual supply of contacts	\$250 allowance (copay waived; instead of eyeglasses)	\$50 copay for fitting exam and annual supply of contacts
Frequency (last service date)	1 x every 12 months	1 x every 12 months	1 x every 12 months	1 x every 12 months
Kids Care Benefit Children 17 and under	Eligible for two covered exams, if needed, every 12-months. Additional lenses with a minimum prescription change, and frames every 12 months (plans 4 and 4x) are included.			
Computer Vision Care	Expanded exam to detect eye health issues related to extensive use of computers and digital devices, plus a \$130 retail frame allowance on eyewear specifically designed to reduce eyestrain and fatigue from daily use of devices.			