



Sierra Sands Unified School District
Classified School Employee Association (CSEA) 2026-2027

	40095D	40095J	40095K	40096A	40096B	M598	70195B no dental/vision
Premium with VSP vision plan	\$776.71	\$698.91	\$600.71	\$553.11	\$490.71	\$600.71	\$106.03 INDV
Premium with XP Health plan	\$787.51	\$709.71	\$611.51	\$563.91	\$501.51	\$611.51	\$169.50 FAM
Part Time 6.5 to 7.25 hr Employee	Anthem	Anthem	Anthem	Anthem	Anthem	ProactiveCare	Anthem
10 Monthly Premiums September - June	PPO	PPO	PPO	PPO	PPO	PPO	PPO
	100-B \$20	90-A \$20	90-C \$20	80-C \$20	80-E \$20	Diamond	2-Tier HSA \$5,000

Maternity Example	\$120	\$1,000	\$1,000	\$1,000	\$1,000	\$200	\$6,350
Diabetes Example	\$710	\$710	\$800	\$710	\$710	\$200	\$5,120
Fractured Foot Example	\$350	\$810	\$900	\$1,010	\$1,010	\$790	\$5,080

¹Examples are based on the federal SBC examples, but updated with actual SISC Costs.

MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles (Ded)	\$100/\$300	\$100/\$300	\$200/\$500	\$200/\$500	\$300/\$600	\$0/\$0	\$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	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$6,350/\$12,700*

*Includes Rx

PROFESSIONAL SERVICES

Primary Care* visit co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$20	\$20	\$20	\$20	\$20	\$0	Deductible, then 30% after Ded
Urgent Care co-pay	\$20	\$20	\$20	\$20	\$20	\$0	30% after Ded
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$20	\$20	\$0	30% after Ded
Specialists/Consultants co-pay	\$20	\$20	\$20	\$20	\$20	\$40	30% after Ded
						Non-Hosp/OPH**	
Scans: CT, CAT, MRI, PET etc.	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$100/\$250	30% after Ded
Laboratory Procedures	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$0/\$50	30% after Ded
Diagnostic X-rays	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$25/\$75	30% after Ded
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% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	\$0	0% after Ded Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (copay waived if admitted) - Avg Cost: \$2,847 \$100+10%: \$375 \$100+20%: \$649	0% after Ded \$100 co-pay	10% after Ded \$100 co-pay	10% after Ded \$100 co-pay	20% after Ded \$100 co-pay	20% after Ded \$100 co-pay	\$300	30% after Ded \$100 co-pay
Inpatient Hospital (preauthorization required) - Avg Cost for one day: \$6,067 10%: \$607 20%: \$1,213	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$200/day	30% after Ded
Surgery, Outpatient (performed in Surgery Center)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$200	30% after Ded
Surgery, Outpatient (performed in a Hospital) - limits may apply	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$600	30% after Ded

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$200/day	30% after Ded
OUTPATIENT: Facility Based Care (preauth required)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$0	30% after Ded

OTHER SERVICES

Ambulance (Ground or Air)	0% after Ded \$100 co-pay	10% after Ded \$100 co-pay	10% after Ded \$100 co-pay	20% after Ded \$100 co-pay	20% after Ded \$100 co-pay	\$300	30% after Ded \$100 co-pay
Acupuncture - Limits apply	0% after Ded Subject to PA	10% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	\$0	30% after Ded Subject to PA
Chiropractic - Limits apply	0% after Ded Subject to PA	10% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	\$0	30% after Ded Subject to PA
Physical and Occupational Therapy - Limits apply	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$0	30% after Ded
Durable Medical Equipment (DME)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	\$0	30% after Ded
Hearing Aids	Amount in excess of \$700 allowance/24 months	10% after Ded and Amount in excess of \$700 allowance/24 months	10% after Ded and Amount in excess of \$700 allowance/24 months	20% after Ded and Amount in excess of \$700 allowance/24 months	20% after Ded and Amount in excess of \$700 allowance/24 months	\$0 plus the amount in excess of \$700 allowance/24 months	10% after Ded and Amount in excess of \$700 allowance/24 months

*Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

**"non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting

PHARMACY BENEFITS

Plan	Rx 7-25	Rx 7-25	Rx 9-35	Rx 7-25	Rx 7-25	Rx 9-35 PC	Rx HSA
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	none	none	Included w/ Medical
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$1,500/\$2,500	\$1,500/\$2,500	\$2,500/\$3,500	\$1,500/\$2,500	\$1,500/\$2,500	\$2,500/\$3,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco‡ \$7 at Other Network	\$0 at Costco‡ \$7 at Other Network	\$0 at Costco‡ \$9 at Other Network	\$0 at Costco‡ \$7 at Other Network	\$0 at Costco‡ \$7 at Other Network	\$0 at Costco‡ \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other
Brand co-pay/30 days supply	\$25	\$25	\$35	\$25	\$25	\$35	Deductible, then
Specialty co-pay/up to 30 days supply	\$25 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60‡	\$0-\$60‡	\$0-\$90‡	\$0-\$60‡	\$0-\$60‡	\$0-\$90‡	Deductible, then \$0-
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 comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions.

Employee cost/payroll deduction, if applicable, can be requested from the district.

‡Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.