



Sierra Sands Unified School District
Confidential and Management 2026-2027

	40095F	40095G	40820A	40820B	40820C	40095H*	M599
Premium with VSP vision plan	\$518.12	\$440.32	\$342.12	\$294.52	\$232.12	(\$381.48)	\$342.12
Premium with XP Health plan	\$528.92	\$451.12	\$352.92	\$305.32	\$242.92	(\$370.68)	\$352.92
	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	ProactiveCare
	PPO	PPO	PPO	PPO	PPO	PPO	PPO
10 Monthly Premiums September - June	100-B \$20	90-A \$20	90-C \$20	80-C \$20	80-E \$20	80-M \$40	Diamond

Maternity Example	\$120	\$1,000	\$1,000	\$1,000	\$1,000	\$4,000	\$200
Diabetes Example	\$710	\$710	\$800	\$710	\$710	\$1,040	\$200
Fractured Foot Example	\$350	\$810	\$900	\$1,010	\$1,010	\$3,630	\$790

*Examples 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	\$3,000/\$6,000	\$0/\$0
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	\$4,000/\$8,000	\$1,000/\$3,000

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	\$40	\$0
Urgent Care co-pay	\$20	\$20	\$20	\$20	\$20	\$40	\$0
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$20	\$20	\$40	\$0
Specialists/Consultants co-pay	\$20	\$20	\$20	\$20	\$20	\$40	\$40
							Non-Hosp/OPH**
Scans: CT, CAT, MRI, PET etc.	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$100/\$250
Laboratory Procedures	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$0/\$50
Diagnostic X-rays	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$25/\$75
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% after Ded Ded Waived	\$0

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	20% after Ded \$100 co-pay	\$300
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	20% after Ded	\$200/day
Surgery, Outpatient (performed in Surgery Center)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$200
Surgery, Outpatient (performed in a Hospital) - limits may apply	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$600

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

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	20% after Ded \$100 co-pay	\$300
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	20% after Ded Subject to PA	\$0
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	20% after Ded Subject to PA	\$0
Physical and Occupational Therapy - Limits apply	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$0
Durable Medical Equipment (DME)	0% after Ded	10% after Ded	10% after Ded	20% after Ded	20% after Ded	20% after Ded	\$0
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	20% after Ded and Amount in excess of \$700 allowance/24 months	\$0 plus the 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 200/10-35	Rx 9-35 PC
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	none	\$200/\$500	none
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	\$2,500/\$3,500
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‡ \$10 at Other Network	\$0 at Costco‡ \$9 at Other Network
Brand co-pay/30 days supply	\$25	\$25	\$35	\$25	\$25	\$35	\$35
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	\$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60‡	\$0-\$60‡	\$0-\$90‡	\$0-\$60‡	\$0-\$60‡	\$0-\$90‡	\$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 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.