

**SIERRA SANDS UNIFIED SCHOOL DISTRICT  
7 HR CLASSIFIED HEALTH BENEFITS ENROLLMENT FORM 2020-2021**



**SIERRA SANDS** Unified School District

<input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Spouse/Domestic Partner Open Enrollment		Effective Date:	
<input type="checkbox"/> New Hire		<input type="checkbox"/> Status Change		Hire Date:	
<input type="checkbox"/> Qualifying Event:				Event Date:	
EMPLOYEE LAST NAME		FIRST NAME	MI	SOCIAL SECURITY # / EMPLOYEE ID #	
ADDRESS		CITY	ZIP	PHONE #	
GENDER	BIRTHDATE	MARITAL STATUS	LIST SPOUSE/DOMESTIC PARTNER IF COVERED BY A PARTICIPATING SISC DISTRICT		
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER	Name: SSN #:		
PLEASE ENROLL ME IN THE PLAN SELECTED BELOW.				FOR INSURANCE STAFF USE ONLY	
<b>Classified - 7 Hour Employee</b>			<b>Employee Monthly Premium</b>		Date
					Posted
<b>X</b>	<b>PLAN</b>	<b>GROUP #</b>	<b>w/o DES</b>	<b>w/ DES</b>	
	100 B \$0	40095D	\$ 557.20	\$ 422.34	
	90 A \$20	40095J	\$ 246.20	\$ 189.09	
	90-D \$10	40095K	\$ 403.40	\$ 306.99	
			Single Employee Only	Employee + Child(ren)	
	Anchor Bronze	70195B	\$ 84.95	\$ 133.33	
<b>NOTE: DES = District Employed Spouse.</b>					
<b>Plan changes will be in effect as of 10/1/20. Information must be submitted to the Business Office by 8/24/20 in order to process before open enrollment closes.</b>					
Employee Signature:					Date:



**SISC**

Self-Insured Schools of California  
Schools Helping Schools

PPO Anthem PPO Anthem PPO Anthem PPO Anthem

**Sierra Sands Unified School District**

**Classified School Employees Association (CSEA)**

	40095D	40095J	40095K	70195B
<b>7 Hour Employees</b>	<b>\$ 557.20</b>	<b>\$ 246.20</b>	<b>\$ 403.40</b>	<b>\$ 84.95</b>
<b>2020-2021</b>	<b>Anthem</b>	<b>Anthem</b>	<b>Anthem</b>	<b>Anthem</b>
<b>10 Monthly Premiums September - June</b>	<b>100-B \$0 (Non-Marketed)</b>	<b>90-A \$20</b>	<b>90-D \$10 (Non-Marketed)</b>	<b>Anchor Bronze (HSA Compatible)</b>
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
Individual/Family Deductibles	\$100/\$300	\$100/\$300	\$200/\$500	\$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	\$6,350/\$12,700*
				*Includes Rx
<b>PROFESSIONAL SERVICES</b>				
Office Visit (OV) co-pay	\$0	\$20	\$10	Deductible, then 30%
Urgent Care co-pay	\$0	\$20	\$10	30%
Specialists/Consultants co-pay	\$0	\$20	\$10	30%
Prenatal, postnatal office visit co-pay	\$0	\$20	\$10	30%
Scans: CT, CAT, MRI, PET etc.	0%	10%	10%	30%
Diagnostic X-ray & Laboratory Procedures	0%	10%	10%	30%
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived
<b>HOSPITAL &amp; SKILLED NURSING FACILITY SERVICES</b>				
Emergency Room visit (waived if admitted)	0% \$100 co-pay	10% \$100 co-pay	10% \$100 co-pay	30% \$100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	10%	30%
Outpatient Hospital	0%	10%	10%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	10%	30%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	10%	30%
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE TREATMENT</b>				
<b>INPATIENT:</b> Facility Based Care (preauth required)	0%	10%	10%	30%
<b>OUTPATIENT:</b> Facility Based Care (preauth required)	0%	10%	10%	30%
<b>OTHER SERVICES</b>				
Acupuncture - Limits apply	0%	10%	10%	30%
Ambulance (Ground or Air)	0%	10%	10%	30%
Chiropractic - Limits apply	0%	10%	10%	30%
Durable Medical Equipment (DME)	0%	10%	10%	30%
Physical and Occupational Therapy - Limits apply	0%	10%	10%	30%
<b>PHARMACY BENEFITS</b>				
<b>Plan</b>	<b>7-25</b>	<b>7-25</b>	<b>9-35</b>	<b>Anchor Bronze Rx</b>
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	Included w/ Medical ded
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	Included w/ Med OOP Max
Generic co-pay/30 day supply	\$0 at Costco	\$0 at Costco	\$0 at Costco	Deductible, then
Brand co-pay/30 day supply	\$25	\$25	\$35	Deductible, then
Specialty co-pay/up to 30 day supply	\$25 Must Use	\$25 Must Use	\$35 Must Use	Deductible, then
Mail Order (Generic-Brand co-pay/90 day supply)	\$0-\$60	\$0-\$60	\$0-\$90	Deductible, then
Mail Order Pharmacy	Costco Mail	Costco Mail	Costco Mail	Costco Mail Order

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.