

**Fullerton Joint Union High School District Insurance Benefits**

*The following deductions are scheduled to continue for 10 regular school-year paychecks*

Anthem Blue Cross HMO	Single (Employee ONLY)- NO PAYROLL DEDUCTION
Anthem Blue Cross HMO	Two Party (Employee + 1 dependent)- NO PAYROLL DEDUCTION
Anthem Blue Cross HMO	Family (Employee + multiple dependents) - NO PAYROLL DEDUCTION

Kaiser-HMO \$20 Co-pay (Single, Two Party, Family) NO PAYROLL DEDUCTION

Anthem Blue Cross PPO 80-G	Single (Employee ONLY)- \$112.73/ Month PAYROLL DEDUCTION
Anthem Blue Cross PPO 80-G	Two Party ( Employee + 1 dependent)-\$237.86/ Month PAYROLL DEDUCTION Family
Anthem Blue Cross PPO 80-G	(Employee + multiple dependents)-\$330.24/ Month PAYROLL DEDUCTION

Anthem Blue Cross PPO 90-E	Single (Employee ONLY)- \$123.38/ Month PAYROLL DEDUCTION
Anthem Blue Cross PPO 90-E	Two Party (Employee + 1 dependent)- \$261.24/ Month PAYROLL DEDUCTION Family
Anthem Blue Cross PPO 90-E	(Employee + multiple dependents) - \$363.31/ Month PAYROLL DEDUCTION

Anthem Blue Cross PPO 100-G	Single (Employee ONLY)- \$128.95/ Month PAYROLL DEDUCTION
Anthem Blue Cross PPO 100-G	Two Party (Employee + 1 dependent)-\$273.32/ Month PAYROLL DEDUCTION Family
Anthem Blue Cross PPO 100-G	(Employee + multiple dependents)-\$380.33/ Month PAYROLL DEDUCTION

**\*\*For details/Benefit Summaries visit:**

[WWW.FJUHSD.ORG](http://WWW.FJUHSD.ORG)

**Go to Departments/Human Resources/Insurance**

**\*Part-time employees looking to cover dependents will need to contact Human Resources for rates.**

**You may refer to your union contracts (page 21) for details on dependent eligibility.**



District Name  
Bargaining Unit

Fullerton Joint Union High School  
ALL

2021-2022	Anthem	Anthem	Anthem	Anthem	Kaiser
	100-G \$20	90-E \$20 (Non-Marketed)	80-G \$20	Premier 10	Trad HMO \$20
<b>MEDICAL - CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
Individual/Family Deductibles	\$500/\$1,000	\$300/\$600	\$500/\$1,000	\$0/\$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	\$2,000/\$4,000	\$1,000/\$2,000	\$1,500/\$3,000

**PROFESSIONAL SERVICES**

Office Visit (OV) co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$20	\$20	\$20	\$10	\$20
Urgent Care co-pay	\$20	\$20	\$20	\$10	\$20
Specialists/Consultants co-pay	\$20	\$20	\$20	\$10	\$20
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$10	\$0
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	\$100/test	\$0
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	\$0	\$0
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	50%	Co-pay applies
Preventive Care (includes physical exams & screenings)	0%	0%	0%	\$0	\$0

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

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

**MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT**

INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	\$0	\$0
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	\$0	\$20

**OTHER SERVICES**

Ambulance (Ground or Air)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	\$100	\$50
Acupuncture - Limits apply	0%	10%	20%	\$10/30 visits combined w/chiro	\$10/30 visits combined w/chiro
Chiropractic - Limits apply	0%	10%	20%	\$10/30 visits combined w/acu	\$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	10%	20%	0%	no charge
Physical and Occupational Therapy - Limits apply	0%	10%	20%	\$10	\$20
Hearing Aids	Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months	50% Coinsurance 1 device per ear/36 months	amount in excess of \$500 allowance every 36 months

**PHARMACY BENEFITS**

Plan	9-35	9-35	9-35	7-25	Trad HMO \$20
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$2,500/\$3,500	\$2,500/\$3,500	\$2,500/\$3,500	\$1,500/\$2,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco \$9 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$9 at Other Network	\$0 at Costco \$7 at Other Network	\$10 up to 100 day supply
Brand co-pay/30 days supply	\$35	\$35.00	\$35.00	\$25.00	\$20 up to 100 day supply
Specialty co-pay/up to 30 days supply	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$25 Must Use Navitus Mail	\$20 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$60	\$10-\$20/up to 100 day supply
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco 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.