Certificated Plan Summary Comparision

CUSD Certificated Healthcare Plans	40310B	40396A	40310D	40310F	40310H
Percentage of Coverage/ Cost of Office Visit	**100-A $10**	**100-D $20**	**80-G $30**	**80-L $30**	**Min. Value PPO**
ANTHEM BLUECROSS MEDICAL- Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0	$300/$600	$500/$1,000	$2,000/$4,000	$5,000/$10,000
Individual/Family Out-of-Pocket (OOP) Max (incl. medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$4,000/$8,000	$6,350/$12,700
PROFESSIONAL SERVICES					
Office Visit (OV) co-pay	$10	$20	$30	$30	30%
Urgent Care co-pay	$10	$20	$30	$30	30%
Specialists/Consultants co-pay	$10	$20	$30	$30	30%
Prenatal, postnatal office visit co-pay	$10	$20	$30	$30	30%
Scans: CT, CAT, MRI, PET etc.	0%	0%	20%	20%	30%
Diagnostic X-ray & Laboratory Procedures	0%	0%	20%	20%	30%
Infertility (diagnosis/treatment)	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care (incl. physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit (waived if admitted)	$100 co-pay	$100 co-pay + 0%	$100 co-pay + 20%	$100 co-pay + 20%	$100 co-pay + 30%
Inpatient Hospital (preauthorization required)	0%	0%	20%	20%	30%
Outpatient Hospital	0%	0%	20%	20%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	0%	20%	20%	30%
Surgery, Outpatient (performed in a Hospital)	0%	0%	20%	20%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT					
INPATIENT: Facility Based Care (preauth required)	0%	0%	20%	20%	30%
OUTPATIENT: Facility Based Care (preauth required)	$10 co-pay	0%	20%	20%	30%
OTHER SERVICES					
Acupuncture - ***Limits apply***	0%	0%	20%	20%	30%
Ambulance (Ground or Air)	$100 co-pay	$100 co-pay	$100 co-pay + 20%	$100 co-pay + 20%	$100 co-pay + 30%
Chiropractic - ***Limits apply***	0%	0%	20%	20%	30%
Durable Medical Equipment (DME)	0%	0%	20%	20%	30%
Physical and Occupational Therapy - ***Limits apply***	0%	0%	20%	20%	30%
PHARMACY BENEFITS	**9-35**	**200/10-35**	**200/10-35**	**200/10-35**	**MVP 9/35**
Individual/Family Brand & Specialty Rx Deductibles	None	200	200	200	$5,000/$10,000
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$6,360/$12,700
Generic co-pay/30 days supply	$0 at Costco $9 at Other	$0 at Costco $10 at Other	$0 at Costco $10 at Other	$0 at Costco $10 at Other	$0 at Costco $9 at Other
Brand co-pay/30 days supply	$35	$35	$35	$35	$35
Specialty co-pay/up to 30 days supply	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35
VISION BENEFITS	**Same for all Plans**				
VSP PLAN C $15 **2194175A**	Exam/Lenses/Frames 12 mos. Co-pays Exam/Frames/Glasses $15				
DENTAL BENEFITS	**Choose One**				
Delta Dental - PPO Premier (2000) **7074-7010**	70% to start and advances to 100% - No Orthodontia $2,200 per person In-Network and $2,000 per person Out-of-Network				
Delta Dental - PPO Unlimited **7074-7310**	100% In-Network and 50% Out-of-Network Unlimited per person In-Network and $1,000 per person Out-of-Network				