SANDERS UNIFIED SCHOOL DISTRICT

Current Medical Benefit Summary

	PLAN 1		PLAN 2	
	In-network	Non-network	In-network	Non-network
Annual Deductible	$750/Individual $1,500/Family	$1,875/Individual $3,750/Family	$500/Individual $1,000/Family	$1,250/Individual $2,500/Family
Annual Out of Pocket Maximum	$2,750/Individual $5,500/Family	$26,875/Individual $53,750/Family	$2,000/Individual $4,000/Family	$26,250/Individual $52,500/Family
Annual Maximum	unlimited		unlimited	
Office Visit	Plan pays 100% after $40 Copay	Plan pays 50% after deductible	Plan pays 100% after $30 Copay	Plan pays 50% after deductible
Well Adult Care	Plan pays 100%	No Coverage	Plan pays 100%	No Coverage
Well Child Care	Plan pays 100%	No Coverage	Plan pays 100%	No Coverage
Diagnostic Lab & X-ray	Plan pays 80% after Deductible	Plan pays 50% after deductible	Plan pays 80% after Deductible	Plan pays 50% after deductible
Other Diagnostic Services - Per Visit	Plan pays 100% after $40 Copay	Plan pays 50% after deductible	Plan pays 100% after $30 Copay	Plan pays 50% after deductible
Urgent Care	Plan pays 100% after $50 Copay	Plan pays 50% after deductible	Plan pays 100% after $40 Copay	Plan pays 50% after deductible
Emergency	Plan pays 80% after Deductible	Plan pays 80% after Deductible	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Hospital - Inpatient	Plan pays 80% after Deductible	Plan pays 50% after deductible	Plan pays 80% after Deductible	Plan pays 50% after deductible
Other Outpatient Facility Charges	Plan pays 100% after $50 Copay	Plan pays 50% after deductible	Plan pays 100% after $40 Copay	Plan pays 50% after deductible
Behavioral Health - Inpatient	Plan pays 80% after Deductible	Plan pays 50% after deductible	Plan pays 80% after Deductible	Plan pays 50% after deductible
Outpatient Mental Health	Plan pays 100% after $50 Copay	Plan pays 50% after deductible	Plan pays 100% after $40 Copay	Plan pays 50% after deductible
Outpatient Substance Abuse	Plan pays 100% after $50 Copay	Plan pays 50% after deductible	Plan pays 100% after $40 Copay	Plan pays 50% after deductible
Prescription Drugs				
Retail:				
Generic Drug	$5 Co-pay		$5 Co-pay	
Preferred Brand Drug	$40 Co-pay		$40 Co-pay	
Non-Preferred Brand Drug	$55 Copay		$55 Copay	
Speciality Drugs	80% to a max of $150		80% to a max of $150	
Mail Order :				
Generic Drug	$10 Co-pay		$10 Co-pay	
Preferred Brand Drug	$80 Co-pay		$80 Co-pay	
Non-Preferred Brand Drug	$110 Co-pay		$110 Co-pay	
Speciality Drugs	80% to a max of $300		80% to a max of $300	

Dental Benefit Summary

Plan Maximums	
Calendar Year Maximum Benefit	$2,000 per person
Orthodontia Lifetime Maximum Benefit - Limited to age 19	$2,400 per person
Calendar Year Deductible	$50 per person
Eligible Dental Expenses	
Preventative Services	100% no deductible
Limited to certain Preventative Services: - routine oral exam and cleanings limited to 2 exams/cleaning per CY; - fluoride treatment is limited to children under 19 and 1 application per CY; - sealants are limited to children under age 14 and once per year	
Basic Services	100% after deductible
Major Services	100% after deductible
Orthodontia	100% after deductible

-Dependents under age 19 have no calendar year maximum

Vision Benefit Summary

Eligible Vision Expenses	
Eye Examination - Limited to 1 eye examination per 12 month period	Plan pays 100% up to $125
Hardware (glasses) or Contacts - $300 benefit renews every 12 month period	Plan pays 100% up to $300
Exclusions and Limitations: - Non-professional care - Orthoptics - Non-prescription lenses - Safety goggles - Sunglasses - Training	

-Dependents under age 19 have no exam limit