

	<b>Certificated</b>																		
<b>PPO PLANS</b>	<b>80% C \$30</b>																		
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)</b>	<b>Member Pays</b>																		
Individual/Family Deductibles	\$200/\$500																		
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	\$1,000/\$3,000																		
<b>PROFESSIONAL SERVICES</b>																			
Office Visit co-pay (\$0 Copay for first 3 calendar year Primary Care office visits)	\$30																		
Urgent Care co-pay	\$30																		
Specialists/Consultants co-pay	\$30																		
Prenatal, postnatal office visit co-pay	\$30																		
Scans: CT, CAT, MRI, PET etc.	20%																		
Diagnostic X-ray & Laboratory Procedures	20%																		
Infertility (diagnosis/treatment of causes of infertility)	Not covered																		
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived																		
<b>HOSPITAL &amp; SKILLED NURSING FACILITY SERVICES</b>																			
Emergency Room visit co-pay (waived if admitted)	20% \$200 co-pay																		
Inpatient Hospital co-pay (preauthorization required)	20%																		
Outpatient Hospital co-pay	20%																		
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	20%																		
Surgery, Outpatient (performed in a Hospital)	20%																		
<b>MENTAL HEALTH SERVICES &amp; SUBSTANCE ABUSE TREATMENT</b>																			
<b>INPATIENT CARE:</b> Facility based care (preauthorization required)	20%																		
<b>OUTPATIENT CARE:</b> Facility based care (preauthorization required)	Deductible waived office visit co-pay applies																		
<b>OTHER SERVICES</b>																			
Acupuncture - Limits apply	20%																		
Ambulance (Ground or Air)	\$100 Co Pay + 20%																		
Chiropractic - Limits apply	20%																		
Durable Medical Equipment (DME)	20%																		
Physical and Occupational Therapy - Limits apply	20%																		
<b>PRESCRIPTION DRUG PLANS</b>																			
Generic co-pay/days supply	\$5/30-Days																		
Brand Deductible Individual/Family	\$100/\$300																		
Brand co-pay/days supply	\$20/30-Days																		
Mail Order (Generic-Brand co-pay/days supply)	\$0-\$50/90-Days																		
Individual/Family RX Out-of-pocket (OOP) Max (Includes Rx deductibles and co-pays)	\$2,500/\$3,500																		
<b>Vision Service Plan (www.vsp.com)</b>	Plan B, \$10 co-pay Exam & lenses every yr; frames every 2 yrs																		
<b>Delta Dental Plan: (www.deltadentalca.org)</b>	Premier Incentive Plan, \$1,500 cal yr max. Ortho 50% up to \$1,000 lifetime.																		
<b>Life Insurance - Reductions begin @ Age 75</b>	\$50,000																		
<b>VUSD/EMPLOYEE CONTRIBUTIONS</b>																			
	<b>2025-26</b>																		
	<b>Certificated</b>																		
Health Plan Annual Cost	<b>\$18,761.16</b>																		
VUSD Annual Contribution	\$16,553.66																		
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<b>TOTAL ANNUAL EMPLOYEE CONTRIBUTION</b>	<b>VARIES PER EMPLOYEE (SEE ABOVE)</b>																		
<small>*Employee Deductions: 11 month (No deduction in July)</small>																			

*This sheet is only a brief summary of benefits that reflects In-Network benefits. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.*

*OOP maximum on Anthem plans with a Navitus pharmacy carve out does not include prescription drug co-pays.*

*Coinurance and co-pays do NOT carryover to the next calendar year.*

*Plans with a deductible all have 4th quarter carryover (October 1 - December 31)*

*For plans with a deductible, co-insurance applies after the deductible has been met unless otherwise noted.*