



PPO PLANS	40605A	40605D	40605H
	100% D \$20 (Non-Marketed)	90% C \$20	80% G \$30
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)			
	Member Pays		Member Pays
Individual/Family Deductibles	\$300/\$600	\$200/\$500	\$500/\$1,000
Individual/Family Out-of-Pocket Max (includes medical deductibles, coinsurance and co-pays)	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$4,000

PROFESSIONAL SERVICES

Office Visit (OV) co-pay (\$0 Copay for first 3 calendar year Primary Care office visits on Non-HSA PPO plans)	\$20	\$20	\$30
Urgent Care co-pay	\$20	\$20	\$30
Specialists/Consultants co-pay	\$20	\$20	\$30
Prenatal, postnatal office visit co-pay	\$20	\$20	\$30
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%
Diagnostic X-ray & Laboratory Procedures (no out-of-network)	0%	10%	20%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	0%	0%	0%

HOSPITAL & SKILLED NURSING FACILITY SERVICES

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

MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT

INPATIENT CARE: Facility based care (preauthorization required)	0%	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies

OTHER SERVICES

Acupuncture - Limits apply	0%	10%	20%
Ambulance (Ground or Air)	\$100 Co Pay	\$100 Co Pay + 10%	\$100 Co Pay + 20%
Chiropractic - Limits apply (no out-of-network)	0%	10%	20%
Durable Medical Equipment (DME) (no out-of-network)	0%	10%	20%
Physical and Occupational Therapy - Limits apply (no out of network)	0%	10%	20%

PRESCRIPTION DRUG PLANS

Individual/Family Brand & Specialty Rx Deductibles	\$200/\$300		\$200/\$300		\$200/\$300	
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$2,500/\$2,500		\$2,500/\$2,500		\$2,500/\$2,500	
Generic co-pay/days supply	\$10/30-Days		\$10/30-Days		\$10/30-Days	
Brand co-pay/days supply	\$35/30-Days		\$35/30-Days		\$35/30-Days	
Mail Order (Generic-Brand co-pay/days supply)	\$0-\$90/90-Days		\$0-\$90/90-Days		\$0-\$90/90-Days	
Vision Service Plan (www.vsp.com)	Plan C, \$10 co-pay Exam, lenses & frames every calendar yr		Plan C, \$10 co-pay Exam, lenses & frames every calendar yr		Plan C, \$10 co-pay Exam, lenses & frames every calendar yr	
Delta Dental Plan: (www.deltadentalca.org)	Premier Incentive Plan, \$1,500 cal yr max.	PPO, \$3,000 cal yr max; Ortho \$2,250 Lifetime max	Premier Incentive Plan, \$1,500 cal yr max.	PPO, \$3,000 cal yr max; Ortho \$2,250 Lifetime max	Premier Incentive Plan, \$1,500 cal yr max.	PPO, \$3,000 cal yr max; Ortho \$2,250 Lifetime max

RATES

	40605A	40605D	40605H
Medical	\$1,706.00	\$1,706.00	\$1,652.00
Dental	\$93.00	\$113.50	\$93.00
Vision	\$23.60	\$23.60	\$23.60
TOTAL PER EMP/MO	\$1,822.60	\$1,843.10	\$1,768.60
ANNUAL PREMIUM	\$21,871.20	\$22,117.20	\$21,223.20
DISTRICT CONTRIBUTION	\$17,551.20	\$17,551.20	\$17,551.20
DIFFERENCE PER EMP/10 MO Deduct	\$432.00	\$456.60	\$367.20

NOTATIONS:

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.

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

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

The district may not partially pay reimburse or otherwise reduce the member's OOP responsibility

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