



	Classified			
PPO PLANS	80% E \$30		80% C \$30	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	Member Pays		Member Pays	
	Spousal Overlay			
Individual/Family Deductibles	\$300/\$600		\$200/\$500	
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	\$1,000/\$3,000		\$500/\$1,500	
PROFESSIONAL SERVICES				
Office Visit co-pay (\$0 Copay for first 3 calendar year Primary Care office visits)	\$30		\$30	
Urgent Care co-pay	\$30		\$30	
Specialists/Consultants co-pay	\$30		\$30	
Prenatal, postnatal office visit co-pay	\$30		\$30	
Scans: CT, CAT, MRI, PET etc.	20%		20%	
Diagnostic X-ray & Laboratory Procedures	20%		20%	
Infertility (diagnosis/treatment of causes of infertility)	Not covered		Not covered	
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived		0%, Deductible Waived	
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit co-pay (waived if admitted)	20% \$200 co-pay		20% \$200 co-pay	
Inpatient Hospital co-pay (preauthorization required)	20%		20%	
Outpatient Hospital co-pay	20%		20%	
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	20%		20%	
Surgery, Outpatient (performed in a Hospital)	20%		20%	
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT				
INPATIENT CARE: Facility based care (preauthorization required)	20%		20%	
OUTPATIENT CARE: Facility based care (preauthorization required)	Deductible waived office visit co-pay applies		Deductible waived office visit co-pay applies	
OTHER SERVICES				
Acupuncture - Limits apply	20%		20%	
Ambulance (Ground or Air)	\$100 Co Pay + 20%		\$100 Co Pay + 20%	
Chiropractic - Limits apply	20%		20%	
Durable Medical Equipment (DME)	20%		20%	
Physical and Occupational Therapy - Limits apply	20%		20%	
PRESCRIPTION DRUG PLANS				
Generic co-pay/days supply	\$10/30-Days		\$10/30-Days	
Brand Deductible Individual/Family	\$200/\$500		\$200/\$500	
Brand co-pay/days supply	\$35/30-Days		\$35/30-Days	
Mail Order (Generic-Brand co-pay/days supply)	\$0-\$90/90-Days		\$0-\$90/90-Days	
Individual/Family RX Out-of-pocket (OOP) Max (Includes Rx deductibles and co-pays)	\$2,500/\$3,500		\$2,500/\$3,500	
Vision Service Plan (www.vsp.com)	Plan B, \$15 co-pay Exam & lenses every yr;frames every 2 yrs		Plan B, \$15 co-pay Exam & lenses every yr;frames every 2 yrs	
Delta Dental Plan: (www.deltadentalca.org)	Premier Incentive Plan, \$1,500 cal yr max. Ortho 50% up to \$1,000 lifetime.		Premier Incentive Plan, \$1,500 cal yr max. Ortho 50% up to \$1,000 lifetime.	
Life Insurance - Reductions Begin @ Age 75	\$60,000			
VUSD/EMPLOYEE CONTRIBUTIONS				
	2025-26		2025-26	
	Classified BASIC PLAN		Classified Plan B	
Health Plan Annual Cost	\$16,168.80		\$16,684.80	
VUSD Annual Contribution	\$16,168.80		\$16,168.80	
	Annual	Monthly	Annual	Monthly (10*)
Employee Contribution	\$0.00	\$0.00	\$516.00	\$51.60
*Employee Deductions: 10 month (No deductions in July or August)				

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.