SISC
Self-Insured Schools of California
Schools Helping Schools

Dinuba Unified School District
Classified Employees
October 1, 2026-27

	40564E		40553D		40564B		40564F		40553C	
PPO PLANS	**80% G $20**		**80% E $20**		**80% C $20**		**90% - A $ 20**		**100% - A $ 10**	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**		**Member Pays**		**Member Pays**		**Member Pays**		**Member Pays**	
Individual/Family Deductibles	$500/$1,000		$300 / $600		$200 / $500		$100/$300		$0/$0	
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$2,000/$4,000		$1,000/$3,000		$1,000/$3,000		$1,000/$3,000		$1,000/$3,000	
PROFESSIONAL SERVICES										
Office Visit (OV) co-pay ($0 Copay for first 3 cal yr Primary Care OV on Non-H S A PPO plans)	$20		$20		$20		$20		$10	
Urgent Care co-pay	$20		$20		$20		$20		$10	
Specialists/Consultants co-pay	$20		$20		$20		$20		$10	
Prenatal, postnatal office visit co-pay	$20		$20		$20		$20		$10	
Scans: CT, CAT, MRI, PET etc.	20%		20%		20%		10%		0%	
Diagnostic X-ray & Laboratory Procedures	20%		20%		20%		10%		0%	
Infertility (diagnosis/treatment of causes of infertility)	Not covered		Not covered		Not covered		Not covered		Not covered	
Preventive Care Services (includes physical exams & screenings)	0%		0%		0%		0%		0%	
HOSPITAL & SKILLED NURSING FACILITY SERVICES										
Emergency Room visit co-pay (waived if admitted)	20%, $100 co-pay		20%, $100 co-pay		20%, $100 co-pay		10%, $100 co-pay		0%, $100 co-pay	
Inpatient Hospital co-pay (preauthorization required)	20%		20%		20%		10%		0%	
Outpatient Hospital co-pay	20%		20%		20%		10%		0%	
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	20%		20%		20%		10%		0%	
Surgery, Outpatient (performed in a Hospital)	20%		20%		20%		10%		0%	
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT										
INPATIENT CARE: Facility based care (preauthorization required)	20%		20%		20%		10%		0%	
OUTPATIENT CARE: Facility based care (preauthorization required)	20%		20%		20%		10%		0%	
OTHER SERVICES										
Acupuncture - Limits apply	20%		20%		20%		10%		0%	
Ambulance (Ground or Air)	20%		20%		20%		10%		0%	
Chiropractic - Limits apply	20%		20%		20%		10%		0%	
Durable Medical Equipment (DME)	20%		20%		20%		10%		0%	
Physical and Occupational Therapy - Limits apply	20%		20%		20%		10%		0%	
PRESCRIPTION DRUG PLANS										
Generic co-pay/days supply	$10/30-Days		$10/30-Days		$5/30-Days		$9/30-Days		$9/30-Days	
Brand Deductible Individual/Family	$200/$500		$200/$500		Not Applicable		Not Applicable		Not Applicable	
Brand co-pay/days supply	$35/30-Days		$35/30-Days		$20/30-Days		$35/30-Days		$35/30-Days	
Mail Order (Generic-Brand co-pay/days supply)	$0-$90/90-Days		$0-$90/90-Days		$0-$50/90-Days		$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		$1,500/$2,500		$2,500/$3,500		$2,500/$3,500	
Vision Service Plan (www.vsp.com)	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses every yr		Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses every yr		Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses every yr		Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses every yr		Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses every yr	
Delta Dental Plan: (www.deltadentalca.org)	Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime.		Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime.		Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime.		Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime.		Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime.	
Life Insurance	$50,000		$50,000		$50,000		$50,000		$50,000	
RATES	2025-26	2026-27	2025-26	2026-27	2025-26	2026-27	2025-26	2026-27	2025-26	2026-27
Medical	$1,238.00	$1,483.00	$1,311.00	$1,571.00	$1,438.00	$1,705.00	$1,662.00	$1,760.00	$1,609.00	$1,921.00
Dental	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20
Vision	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70
Life Insurance	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25
TOTAL PER EMP/MO	**$1,398.15**	**$1,643.15**	**$1,471.15**	**$1,731.15**	**$1,598.15**	**$1,865.15**	**$1,822.15**	**$1,920.15**	**$1,769.15**	**$2,081.15**
ANNUAL PREMIUM	$18,982.80		$19,993.80		$21,580.80		$22,747.80		$24,037.80	
DISTRICT CONTRIBUTION	$16,777.80		$16,777.80		$16,777.80		$16,777.80		$16,777.80	
DIFFERENCE PER EMP/MO (9) (Monthly cost does not include May deduction)	**$245.00**		**$357.33**		**$533.67**		**$663.33**		**$806.67**	

Deductions will vary by member depending on which plan they are currently enrolled in.

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.

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

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)

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