SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Caruthers USD PPO Options -
10/1/2020-9/30/2021

12-Month Employees

PLANS	40672D 100-A $0; Navitus 5-20		40672F 100-B $20; Navitus 5-20		40672E 90-D $10; Navitus 5-20		40727C 80-G $30; Navitus 200 Ded/10-35		40727A 80-L $30; Navitus Rx 200/15-50	
Provider Network(s):										
Hospital	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Professional	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Calendar Year Deductible(s)	$0		$100 per individual up to $300 per family		$200 per individual up to $500 per family		$500 per individual up to $1000 per family		$2,000 per individual up to $4,000 per family	
Out-of-Pocket Maximum	$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$2000 per individual up to $4000 per family		$4,000 per individual up to $8,000 per family	
Out-of-Pocket Maximum is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%).	This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay.		This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance.	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	$0 co-pay	Non-Par Fee	$20 co-pay	Non-Par Fee	$10 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee
Emergency Room (non-emergency)	$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay	
Outpatient Prescription Drugs	**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 200 Brand Ded / 10-35**		**Navitus Rx Plan 200 Brand Ded / 15-50**	
	Retail	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**
Supply	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days
Brand Name Calendar Year Deductible	not applicable		not applicable		not applicable		$200 single/$500 family (per calendar year beginning January 1)		$200 single/$500 family (per calendar year beginning January 1)	
Generic Drugs	$5	$0	$5	$0	$5	$0	$10	$0	$15	$15
Brand Name Drugs	$20	$50	$20	$50	$20	$50	$35	$90	$50	$135

This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

*** All employees have Mutual of Omaha Group Life Insurance billed separately**

Current District Cap $1,203.26 monthly $14,439.14 Annual		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**
Medical		$1,603.00		$1,490.00		$1,459.00		$1,152.00		$1,004.00
Prescription Drugs		In medical		In medical		In medical		In medical		In medical
Psychiatric & Substance Abuse		In medical		In medical		In medical		In medical		In medical
Dental (Option 1)		$133.00		$133.00		$133.00		$133.00		$133.00
Vision		$24.70		$24.70		$24.70		$24.70		$24.70
Billed per month per contract		**$1,760.70**		**$1,647.70**		**$1,616.70**		**$1,309.70**		**$1,161.70**
Billed annually per contract		**$21,128.40**		**$19,772.40**		**$19,400.40**		**$15,716.40**		**$13,940.40**
Monthly (12) out of pocket cost		**$557.44**		**$444.44**		**$413.44**		**$106.44**		**($41.56)**
Dental (Option 2)		$118.40		$118.40		$118.40		$118.40		$118.40
Billed per month per contract		**$1,746.10**		**$1,633.10**		**$1,602.10**		**$1,295.10**		**$1,147.10**
Billed annually per contract		**$20,953.20**		**$19,597.20**		**$19,225.20**		**$15,541.20**		**$13,765.20**
Monthly (12) out of pocket cost		**$542.84**		**$429.84**		**$398.84**		**$91.84**		**($56.16)**
***Mandatory Life Insurance paid monthly**		**4.75**		**4.75**		**4.75**		**4.75**		**4.75**

Updated 3-31-2019 dh

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Caruthers USD PPO Options -
10/1/2020-9/30/2021

11-Month Employees

PLANS	40672D 100-A $0; Navitus 5-20		40672F 100-B $20; Navitus 5-20		40672E 90-D $10; Navitus 5-20		40727C 80-G $30; Navitus 200 Ded/10-35		40727A 80-L $30; Navitus Rx 200/15-50	
Provider Network(s):										
Hospital	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Professional	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Calendar Year Deductible(s)	$0		$100 per individual up to $300 per family		$200 per individual up to $500 per family		$500 per individual up to $1000 per family		$2,000 per individual up to $4,000 per family	
Out-of-Pocket Maximum	$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$2000 per individual up to $4000 per family		$4,000 per individual up to $8,000 per family	
Out-of-Pocket Maximum is the member's responsibility to pay when the plan is paying less than 100% (i.e plan pays 80%, member pays the other 20%)	This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay		This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	$0 co-pay	Non-Par Fee	$20 co-pay	Non-Par Fee	$10 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee
Emergency Room (waved if admitted) Ambulance co-pay not waved	$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay	
Outpatient Prescription Drugs	Navitus Rx Plan 5-20		Navitus Rx Plan 5-20		Navitus Rx Plan 5-20		Navitus Rx Plan 200 Brand Ded / 10-35		Navitus Rx Plan 200 Brand Ded / 15-50	
Supply	Retail 30 days	Mail 90 days	Retail 30 days	Mail 90 days	Retail 30 days	Mail 90 days	Retail 30 days	Mail 90 days	Retail 30 days	Mail 90 days
Brand Name Calendar Year Deductible	not applicable		not applicable		not applicable		$200 single/$500 family (per calendar year beginning January 1)		$200 single/$500 family (per calendar year beginning January 1)	
Generic Drugs	$5	$0	$5	$0	$5	$0	$10	$0	$15	$15
Brand Name Drugs	$20	$50	$20	$50	$20	$50	$35	$90	$50	$135

This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

***All employees have Mutual of Omaha Group Life Insurance billed separately**

Current District Cap $1,203.26 monthly $14,439.14 Annual		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20
Medical		$1,603.00		$1,490.00		$1,459.00		$1,152.00		$1,004.00
Prescription Drugs		In medical		In medical		In medical		In medical		In medical
Psychiatric & Substance Abuse		In medical		In medical		In medical		In medical		In medical
Dental (Option 1)		$133.00		$133.00		$133.00		$133.00		$133.00
Vision		$24.70		$24.70		$24.70		$24.70		$24.70
Billed per month per contract		**$1,760.70**		**$1,647.70**		**$1,616.70**		**$1,309.70**		**$1,161.70**
Billed annually per contract		**$21,128.40**		**$19,772.40**		**$19,400.40**		**$15,716.40**		**$13,940.40**
Monthly (11) out of pocket cost		**$608.11**		**$484.84**		**$451.02**		**$116.11**		**($45.34)**
Dental (Option 2)		$118.40		$118.40		$118.40		$118.40		$118.40
Billed per month per contract		**$1,746.10**		**$1,633.10**		**$1,602.10**		**$1,295.10**		**$1,147.10**
Billed annually per contract		**$20,953.20**		**$19,597.20**		**$19,225.20**		**$15,541.20**		**$13,765.20**
Monthly (11) out of pocket cost		**$592.19**		**$468.91**		**$435.10**		**$100.19**		**($61.27)**
***Mandatory Life Insurance paid monthly**		**4.75**		**4.75**		**4.75**		**4.75**		**4.75**

Updated 3-31-2019 dh

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Caruthers USD PPO Options - 10/1/2020-9/30/2021

11-Month Married Couple

PLANS	40672D 100-A $0; Navitus 5-20		40672F 100-B $20; Navitus 5-20		40672E 90-D $10; Navitus 5-20		40727C 80-G $30; Navitus 200 Ded/10-35		40727A 80-L $30; Navitus Rx 200/15-50	
Provider Network(s):										
Hospital	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Professional	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Calendar Year Deductible(s)	$0		$100 per individual up to $300 per family		$200 per individual up to $500 per family		$500 per individual up to $1000 per family		$2,000 per individual up to $4,000 per family	
Out-of-Pocket Maximum	$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$2000 per individual up to $4000 per family		$4,000 per individual up to $8,000 per family	
Out-of-Pocket Maximum is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%)	This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay		This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	$0 co-pay	Non-Par Fee	$20 co-pay	Non-Par Fee	$10 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee
Emergency Room (waved if admitted) Ambulance co-pay not waved	$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay	
Outpatient Prescription Drugs	Navitus Rx Plan 5-20		Navitus Rx Plan 5-20		Navitus Rx Plan 5-20		Navitus Rx Plan 200 Brand Ded / 10-35		Navitus Rx Plan 200 Brand Ded / 15-50	
	Retail	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**
Supply	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days
Brand Name Calendar Year Deductible	not applicable		not applicable		not applicable		$200 single/$500 family (per calendar year beginning January 1)		$200 single/$500 family (per calendar year beginning January 1)	
Generic Drugs	$5	$0	$5	$0	$5	$0	$10	$0	$15	$15
Brand Name Drugs	$20	$50	$20	$50	$20	$50	$35	$90	$50	$135

This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

***All employees have Mutual of Omaha Group Life Insurance billed separately**

Current District Cap $1,203.26 monthly $14,439.14 Annual		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20		Renewal rate effective 10/01/20
Medical		$1,202.25		$1,117.50		$1,094.25		$864.00		$753.00
Prescription Drugs		In medical		In medical		In medical		In medical		In medical
Psychiatric & Substance Abuse		In medical		In medical		In medical		In medical		In medical
Dental (Option 1)		$133.00		$133.00		$133.00		$133.00		$133.00
Vision		$24.70		$24.70		$24.70		$24.70		$24.70
Billed per month per contract		**$1,359.95**		**$1,275.20**		**$1,251.95**		**$1,021.70**		**$910.70**
Billed annually per contract		**$16,319.40**		**$15,302.40**		**$15,023.40**		**$12,260.40**		**$10,928.40**
Monthly (11) out of pocket cost		**$170.93**		**$78.48**		**$53.11**		**($198.07)**		**($319.16)**
Dental (Option 2)		$118.40		$118.40		$118.40		$118.40		$118.40
Billed per month per contract		**$1,345.35**		**$1,260.60**		**$1,237.35**		**$1,007.10**		**$896.10**
Billed annually per contract		**$16,144.20**		**$15,127.20**		**$14,848.20**		**$12,085.20**		**$10,753.20**
Monthly (11) out of pocket cost		**$155.01**		**$62.55**		**$37.19**		**($213.99)**		**($335.09)**
***Mandatory Life Insurance paid monthly**		**4.75**		**4.75**		**4.75**		**4.75**		**4.75**

Updated 3-31-2019 dh

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Caruthers USD PPO Options -
10/1/2020 - 9/30/2021

10-Month Part-time Employees 6.0

PLANS	40672D 100-A $0; Navitus 5-20		40672F 100-B $20; Navitus 5-20		40672E 90-D $10; Navitus 5-20		40727C 80-G $30; Navitus 200 Ded/10-35		40727A 90-L $30; Navitus Rx 200/15-50	
Provider Network(s):										
Hospital	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Professional	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Calendar Year Deductible(s)	$0		$100 per individual up to $300 per family		$200 per individual up to $500 per family		$500 per individual up to $1000 per family		$2,000 per individual up to $4,000 per family	
Out-of-Pocket Maximum	$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$2000 per individual up to $4000 per family		$4,000 per individual up to $8,000 per family	
Out-of-PocketMaximum is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%).			This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-Insurance.	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	$0 co-pay	Non-Par Fee	$20 co-pay	Non-Par Fee	$10 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee
Emergency Room (non-emergency)	$100 Co-Pay		$100 co-pay		$100 Co-Pay		$100 Co-Pay		$100 Co-Pay	
Outpatient Prescription Drugs	**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 200 Brand Ded / 10-35**		**Navitus Rx Plan 200 Brand Ded / 15-50**	
	Retail	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**
Supply	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days
Brand Name Calendar Year Deductible	not applicable		not applicable		not applicable		$200 single/$500 family (per calendar year beginning January 1)		$200 single/$500 family (per calendar year beginning January 1)	
Generic Drugs	$5	$0	$5	$0	$5	$0	$10	$0	$15	$15
Brand Name Drugs	$20	$50	$20	$50	$20	$50	$35	$90	$50	$135

This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

***All employees have Mutual of Omaha Group Life Insurance billed separately**

District Cap for part-time employee's is 75% of current cap $902.45 per month or $10,829.36 per year

Current District Cap $1,203.25 monthly $14,439.14 Annual		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**
Medical		$1,603.00		$1,490.00		$1,459.00		$1,152.00		$1,004.00
Prescription Drugs		In medical		In medical		In medical		In medical		In medical
Psychiatric & Substance Abuse		In medical		In medical		In medical		In medical		In medical
Dental (Option 1)		$133.00		$133.00		$133.00		$133.00		$133.00
Vision		$24.70		$24.70		$24.70		$24.70		$24.70
Billed per month per contract		**$1,760.70**		**$1,647.70**		**$1,616.70**		**$1,309.70**		**$1,161.70**
Billed annually per contract		**$21,128.40**		**$19,772.40**		**$19,400.40**		**$15,716.40**		**$13,940.40**
Monthly (11) out of pocket cost		**$936.28**		**$813.00**		**$779.19**		**$444.28**		**$282.82**
Dental (Option 2)		$118.40		$118.40		$118.40		$118.40		$118.40
Billed per month per contract		**$1,746.10**		**$1,633.10**		**$1,602.10**		**$1,295.10**		**$1,147.10**
Billed annually per contract		**$20,953.20**		**$19,597.20**		**$19,225.20**		**$15,541.20**		**$13,765.20**
Monthly (11) out of pocket cost		**$920.35**		**$797.08**		**$763.26**		**$428.35**		**$266.89**
***Mandatory Life Insurance paid monthly**		**4.75**		**$4.75**		**$4.75**		**$4.75**		**$4.75**

Updated 3-31-2019 dh

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Caruthers USD PPO Options -
10/1/2020-9/30/2021

10-Month Part-time Employees 6.5

PLANS	40672D 100-A $0; Navitus 5-20		40672F 100-B $20; Navitus 5-20		40672E 90-D $10; Navitus 5-20		40727C 80-G $30; Navitus 200 Ded/10-35		40727A 80-L $30; Navitus Rx 200/15-50	
Provider Network(s):										
Hospital	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Professional	Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer		Prudent Buyer	
Calendar Year Deductible(s)	$0		$100 per individual up to $300 per family		$200 per individual up to $500 per family		$500 per individual up to $1000 per family		$2,000 per individual up to $4,000 per family	
Out-of-Pocket Maximum	$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$1000 per individual up to $3,000 per family		$2000 per individual up to $4000 per family		$4,000 per individual up to $8,000 per family	
Out-of-PocketMaximum is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%)			This plan's Annual Out of Pocket Maximum includes the member's emergency room ambulance $100 co-pay		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	$0 co-pay	Non-Par Fee	$20 co-pay	Non-Par Fee	$10 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee	$30 co-pay	Non-Par Fee
Emergency Room (non-emergency)	$100 Co-Pay		$100 co-pay		$100 Co-Pay		$100 Co-Pay		$100 Co-Pay	
Outpatient Prescription Drugs	**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 5-20**		**Navitus Rx Plan 200 Brand Ded / 10-35**		**Navitus Rx Plan 200 Brand Ded / 15-50**	
	Retail	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**
Supply	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days
Brand Name Calendar Year Deductible	not applicable		not applicable		not applicable		$200 single/$500 family (per calendar year beginning January 1)		$200 single/$500 family (per calendar year beginning January 1)	
Generic Drugs	$5	$0	$5	$0	$5	$0	$10	$0	$15	$15
Brand Name Drugs	$20	$50	$20	$50	$20	$50	$35	$90	$50	$135

This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

***All employees have Mutual of Omaha Group Life Insurance billed separately**

District Cap for part-time employee's is 81% of current cap $974.64 per month or $11,695.70 per year

Current District Cap $1,203.26 monthly $14,439.14 Annual		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**		**Renewal rate effective 10/01/20**
Medical		$1,603.00		$1,490.00		$1,459.00		$1,152.00		$1,004.00
Prescription Drugs		In medical		In medical		In medical		In medical		In medical
Psychiatric & Substance Abuse		In medical		In medical		In medical		In medical		In medical
Dental (Option 1)		$133.00		$133.00		$133.00		$133.00		$133.00
Vision		$24.70		$24.70		$24.70		$24.70		$24.70
Billed per month per contract		**$1,760.70**		**$1,647.70**		**$1,616.70**		**$1,309.70**		**$1,161.70**
Billed annually per contract		**$21,128.40**		**$19,772.40**		**$19,400.40**		**$15,716.40**		**$13,940.40**
Monthly (11) out of pocket cost		**$857.52**		**$734.25**		**$700.43**		**$365.52**		**$204.06**
Dental (Option 2)		$118.40		$118.40		$118.40		$118.40		$118.40
Billed per month per contract		**$1,746.10**		**$1,633.10**		**$1,602.10**		**$1,295.10**		**$1,147.10**
Billed annually per contract		**$20,953.20**		**$19,597.20**		**$19,225.20**		**$15,541.20**		**$13,765.20**
Monthly (11) out of pocket cost		**$841.59**		**$718.32**		**$684.50**		**$349.59**		**$188.14**
***Mandatory Life Insurance paid monthly**		**4.75**		**4.75**		**4.75**		**4.75**		**4.75**

Updated 3-31-2019 dh

KAISER	2020-2021			
	12 Month Employees	11 Month Employees	11 Month Part-time Employees 6.0 hours	11 Month Part-time Employees 6.5 hours
	$0 OV $5 Rx	$0 OV $5 Rx	$0 OV $5 Rx	$0 OV $5 Rx
Composite Rate	$1,303.00	$1,421.45	$1,421.45	$1,421.45
Dental Option 1	$133.00	$145.09	$145.09	$145.09
Vision	$24.70	$26.95	$26.95	$26.95
Total	$1,460.70	$1,593.49	$1,593.49	$1,593.49
District Cap	$1,203.26	$1,312.65	$984.49	$1,063.25
Monthly Cost	**$257.44**	**$280.84**	**$609.00**	**$675.11**
Dental Option 2	$118.40	$129.16	$129.16	$129.16
Vision	$24.70	$26.95	$26.95	$26.95
Total	$1,446.10	$1,577.56	$1,577.56	$1,577.56
District Cap	$1,203.26	$1,312.65	$984.49	$1,063.25
Monthly Cost	**$242.84**	**$264.91**	**$593.08**	**$514.32**
* Life Ins $50,000.00	**$4.75**	**$4.75**	**$4.75**	**$4.75**

* All employees have Lincoln Financial life insurance billed separately (NOT PRE-TAXED)

Emergency Room Co-pay is $100.00 waived if admitted directly to the hospital
Ambulance Co-pay $50.00 per trip

Out-of-Pocket Maximum $1,500 per individual up to #3,000 per family

Kaiser Composit rate does include Chiropractic and Acupuncture Benefits $10.00 copay per visit
Office visit limit: Up to combined total of 30 medically necessary Chiropractic and Acupuncture visits per year

Vision Services Plan (VSP) Plan C Exam, Lenses and Frames every calendar year
You will receive a $150.00 allowance toward any frame of your choice plus 20% off any amount over the allowance

Contact Lens Allowance — every calendar year
$105.00 allowamce for contacts and the contact lens exam (fitting and evaluation)

To add spouse copy of marriage certificate required, to add dependents copy of birth certificate required.

Updated 6-1-20 dh

KAISER	2020-2021 Married Couple In the District	
	12 Month Employees	**11 Month Employees**
	$0 OV $5 Rx	**$0 OV $5 Rx**
Composite Rate	$977.25	$1,066.09
Dental Option 1	$133.00	$145.09
Vision	$24.70	$26.95
Total	$1,134.95	$1,238.13
District Cap	$1,203.26	$1,312.65
Monthly Cost	**($68.31)**	**($74.52)**
Dental Option 2	$118.40	$129.16
Vision	$24.70	$26.95
Total	$1,120.35	$1,222.20
District Cap	$1,203.26	$1,312.65
Monthly Cost	**($82.91)**	**($90.45)**
* Life Ins $50,000.00	**$4.75**	**$4.75**

* All employees have Lincoln Financial life insurance billed separately (NOT PRE-TAXED)

Emergency Room Co-pay is $100.00 waived if admitted directly to the hospital

Ambulance Co-pay $50.00 per trip

Out-of-Pocket Maximum $1,500 per individual up to #3,000 per family

Kaiser Composit rate does include Chiropractic and Acupuncture Benefits $10.00 copay per visit

Office visit limit: Up to a combined total of 30 medically necessary Chiropractic and Acupuncture visits per yea

Vision Services Plan (VSP) Plan C Exam, Lenses and Frames every calendar year

You will receive a $150.00 allowance toward any frame of your choice plus 20% off any amount over the allov

Contact Lens Allowance --- every calendar year

$105.00 allowance for contacts and the contact lens exam (fitting and evaluation)

To add spouse copy of marriage certificate required, to add dependents copy of birth certificate required.

Updated 6-1-20 dh

Plan Summary for Classified, Certificated, and Confidential Management
Rates effective 10-1-2020

www.deltadentalins.com **1-866-499-3001**

Dental (Option 1)
Delta Dental Premier Incentive Plan Cost: $133.00
Group # 7081-1034
70% 1st year
80% 2nd year
90% 3rd year
100% 4th year
No annual plan maximum (unlimited)

Dental (Option2)
****** Delta Dental PPO (DPO) Plan Cost: $118.40**
Group # 7081-1334
Plan pays 100% for In-Network PPO (DPO) Dentist ONLY
Plan pays 50% for Out-of-Network PPO Dentist
Annual maximum $3,000.00 per calendar year per person
Orthodontist coverage $2,000.00 lifetime maximum per person
Please call Delta Dental with any questions

Vision Services Plan www.vsp.com 1-800-877-7195

Vision Services Plan C (VSP) Cost: $24.70
Group # 2217132A
$10.00 office co-pay
Exam and Lenses; and Frames every year
The plan renews every year January 1st
Please call VSP with any questions

All Anthem Blue Cross PPO plans have Chiropractic Services
For Provider information call the number on the back of your Anthem ID card or access the new mobile application called Anthem Sydney Digital ID card

*** The first page of the most current Federal Tax Return AND a copy of the marriage certificated are required for proof of spouse eligibility.
Birth Certificate needed to add each dependent child.

D. Haney 6-1-2020

PPO PLANS	ANCHOR BRONZE
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**
Individual/Family Deductibles	$5,000/$10,000
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$6,350/$12,700

PROFESSIONAL SERVICES

Office Visit co-pay	30% after deductible
Urgent Care co-pay	30% after deductible
Specialists/Consultants co-pay	30% after deductible
Prenatal, postnatal office visit co-pay	30% after deductible
Scans: CT, CAT, MRI, PET etc.	30%
Diagnostic X-ray & Laboratory Procedures	30%
Infertility (diagnosis/treatment of causes of infertility)	Not covered
Preventive Care Services (includes physical exams & screenings)	0%, Ded Waived

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit co-pay (waived if admitted)	30% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	30%
Outpatient Hospital co-pay	30%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	30%
Surgery, Outpatient (performed in a Hospital)	30%

MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT

INPATIENT CARE: Facility based care (preauthorization required)	30%
OUTPATIENT CARE: Facility based care (preauthorization required)	30%

OTHER SERVICES

Acupuncture - Limits apply	30%
Ambulance (Ground or Air)	30%
Chiropractic - Limits apply	30%
Durable Medical Equipment (DME)	30%
Physical and Occupational Therapy - Limits apply	30%

PRESCRIPTION DRUG PLANS

Generic co-pay/days supply	After deductible, $9/ 30-day
Brand co-pay/days supply	After deductible, $35/30-day
Mail Order (Generic-Brand co-pay/days supply)	After deductible, $18-90/90-day

Single	2 Party	Family
$531.00	**$831.00**	**$831.00**

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 and Blue Shield plans with a Navitus pharmacy carve out does not include prescription drug co-pays.

Minimum Value Plans, Health Savings Account Plans and Kaiser HMO or HDHP OOP maximum does 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) with the exception of any Health Savings Account (HSA) plan or Kaiser HDHP plans

The district may not partially pay reimburse or otherwise reduce the member's OOP responsibility unless they contribute to a Health Savings Account (HSA) for the employee.

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

Updated 6-1-20 dh