SISC
Self-Insured Schools of California
*Schools Helping Schools*

Cutler-Orosi Unified School District
Certificated Employees
October 1, 2020-21

| PPO PLANS | 90% - C $20 | 80% - J $30 |
|---|---|---|
| ***CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)*** | **Member Pays** | **Member Pays** |
| Individual/Family Deductibles | $200/$500 | $750/$1,500 |
| Individual/Family Out-of-Pocket Max (includes medical deductibles and co-pays) | $1,000/$3,000 | $3,000/$6,000 |
| ***PROFESSIONAL SERVICES*** | | |
| Office Visit co-pay ($0 copay for first 3 calendar year Primary Care office visits) | $20 | $30 |
| Urgent Care co-pay | $20 | $30 |
| Specialists/Consultants co-pay | $20 | $30 |
| Prenatal, postnatal office visit co-pay | $20 | $30 |
| Scans: CT, CAT, MRI, PET etc. | 10% | 20% |
| Diagnostic X-ray & Laboratory Procedures | 10% | 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) | 10% $100 co-pay | 20% $100 co-pay |
| Inpatient Hospital co-pay (preauthorization required) | 10% | 20% |
| Outpatient Hospital co-pay | 10% | 20% |
| Surgery, Outpatient (performed in an Ambulatory Surgery Center) | 10% | 20% |
| Surgery, Outpatient (performed in a Hospital) | 10% | 20% |
| ***MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT*** | | |
| **INPATIENT CARE:** Facility based care (preauthorization required) | 10% | 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 | 10% | 20% |
| Ambulance (Ground or Air) | $100 Co Pay + 10% | $100 Co Pay + 10% |
| Chiropractic - Limits apply | 10% | 20% |
| Durable Medical Equipment (DME) | 10% | 20% |
| Physical and Occupational Therapy - Limits apply | 10% | 20% |
| ***PRESCRIPTION DRUG PLANS*** | | |
| Brand Deductible - Individual/Family | None | Not Applicable |
| Individual/Family Rx Out-of-Pocket (OOP) Max (Includes RX deductibles & co pays) | $2,500/$3,500 | $2,500/$3,500 |
| Generic co-pay/days supply | $9/30-Days | $9/30-Days |
| 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 |
| **Vision Service Plan (www.vsp.com)** | Plan B, $10 co-pay Exam & lenses every calendar yr; frames every other yr | Plan B, $10 co-pay Exam & lenses every calendar yr; frames every other yr |
| **Delta Dental Plan: (www.deltadentalca.org)** | Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime max. | Premier Incentive Plan, Unlimited cal yr max. Ortho up to $1,000 lifetime max. |
| ***RATES*** | | |
| ***Medical*** | $1,254.00 | $1,079.00 |
| ***Dental*** | $141.20 | $141.20 |
| ***Vision*** | $19.70 | $19.70 |
| **TOTAL PER EMP/MO** | **$1,414.90** | **$1,239.90** |
| **DISTRICT CONTRIBUTION** | $1,239.90 | $1,239.90 |
| **DIFFERENCE PER EMP/MO (12)** | **$175.00** | **$0.00** |

***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 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.***