



SISC
Self-Insured Schools of California
Schools Helping Schools

Cutler-Orosi Unified School District
Certificated Employees
October 1, 2019-20

PPO PLANS	90% - C \$30	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	\$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.	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	Not Applicable	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 50% up to \$1,000 lifetime.	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to \$1,000 lifetime.

RATES

<i>Medical</i>	\$1,220.00	\$1,051.00
<i>Dental</i>	\$143.20	\$143.20
<i>Vision</i>	\$19.70	\$19.70
TOTAL PER EMP/MO	\$1,382.90	\$1,213.90
DISTRICT CONTRIBUTION		
DIFFERENCE PER EMP/MO (12)	#VALUE!	#VALUE!

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.