



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

SCHOOLS HELPING SCHOOLS PPO PLANS	40562B	40562D	40562G	40562H
		100% - A \$20	90% - C \$30	80% - G \$20

CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$200/\$500	\$500/\$1,000	\$750/\$1,500
Individual/Family Out-of-Pocket Max (includes medical deductibles, coinsurance and co-pays)	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$4,000	\$3,000/\$6,000

**PROFESSIONAL SERVICES**

Office Visit co-pay	\$20	\$30	\$20	\$30
Urgent Care co-pay	\$20	\$30	\$20	\$30
Specialists/Consultants co-pay	\$20	\$30	\$20	\$30
Prenatal, postnatal office visit co-pay	\$20	\$30	\$20	\$30
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	20%
Diagnostic X-ray & Laboratory Procedures (In-Network Only)	0%	10%	20%	20%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived

**HOSPITAL & SKILLED NURSING FACILITY SERVICES**

Emergency Room visit co-pay (waived if admitted)	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	20% \$100 co-pay
Inpatient Hospital co-pay (preauthorization required)	0%	10%	20%	20%
Outpatient Hospital co-pay	0%	10%	20%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	0%	10%	20%	20%
Surgery, Outpatient (performed in a Hospital)	0%	10%	20%	20%

**MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT**

INPATIENT CARE: Facility based care (preauthorization required)	0%	10%	20%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies

**OTHER SERVICES**

Acupuncture - Limits apply	0%	10%	20%	20%
Ambulance (Ground or Air)	\$100 Co Pay	\$100 Co Pay + 10%	\$100 Co Pay +20%	\$100 Co Pay +20%
Chiropractic - Limits apply (In-Network only)	0%	10%	20%	20%
Durable Medical Equipment (DME) (In-Network only)	0%	10%	20%	20%
Physical and Occupational Therapy - Limits apply (In-Network Only)	0%	10%	20%	20%

**PRESCRIPTION DRUG PLANS**

Brand Deductible - Individual/Family	None	\$200/\$500	\$200/\$500	\$200/\$500
Individual/Family Rx Out-of-Pocket (OOP) Max (Includes RX deductible & co-pays)	\$1,500/\$2,500	\$2,500/\$3,500	\$2,500/\$3,500	\$2,500/\$3,500
Generic co-pay/days supply	\$7/30-Days	\$10/30-Days	\$10/30-Days	\$10/30-Days
Brand co-pay/days supply	\$25/30-Days	\$35/30-Days	\$35/30-Days	\$35/30-Days
Mail Order (Generic-Brand co-pay/days supply)	\$0-\$60/90-Days	\$0-\$90/90-Days	\$0-\$90/90-Days	\$0-\$90/90-Days
<b>Vision Service Plan (www.vsp.com)</b>	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	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
<b>Delta Dental Plan: (www.deltadentalca.org)</b>	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.	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.

**RATES**

<i>Medical</i>	\$1,360.00	\$1,186.00	\$1,055.00	\$1,017.00
<i>Dental</i>	\$111.20	\$111.20	\$111.20	\$111.20
<i>Vision</i>	\$19.70	\$19.70	\$19.70	\$19.70
<b>TOTAL PER EMP/MO</b>	<b>\$1,490.90</b>	<b>\$1,316.90</b>	<b>\$1,185.90</b>	<b>\$1,147.90</b>
<b>DISTRICT CONTRIBUTION</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>DIFFERENCE PER EMP/MO (12)</b>	<b>\$1,490.90</b>	<b>\$1,316.90</b>	<b>\$1,185.90</b>	<b>\$1,147.90</b>

**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.*

*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.*