PRJUSD Healthcare Plans Certificated	40311G 100-D $20	40312F 80-E $20	40311H 80-G $30	40312C 80-M $40	70312B 70 /2-Tier
BLUECROSS MEDICAL- Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$300/$600	$300/$600	$500/$1000	$3000/$6000	$5000/$10,000
Individ/Family Out-of-Pocket (OOP) Max (incl. medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/ $4,000	$4000/$8000	$6,350/$12,700
PROFESSIONAL SERVICES					
Office Visit (OV) co-pay	$20	$20	$30	$40	30%
Urgent Care co-pay	$20	$20	$30	$40	30%
Specialists/Consultants co-pay	$20	$20	$30	$40	30%
Prenatal, postnatal office visit co-pay	$20	$20	$30	$40	30%
Scans: CT, CAT, MRI, PET etc.	0%	20%	20%	20%	30%
Diagnostic X-ray & Laboratory Procedures	0%	20%	20%	20%	30%
Infertility (diagnosis/treatment)	Not covered	Not covered	Not covered	Not covered	No Covered
Preventive Care (incl. physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					***Limits Apply***
Emergency Room visit (waived if admitted)	$100 co-pay	$100 co-pay	$100 co-pay + 20%	$100 co-pay + 20%	$100 co-pay + 30%
Inpatient Hospital (preauthorization required)	0%	20%	20%	20%	30%
Outpatient Hospital	0%	20%	20%	20%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	20%	20%	20%	30%
Surgery, Outpatient (performed in a Hospital)	0%	20%	20%	20%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT					
INPATIENT: Facility Based Care (preauth required)	0%	20%	20%	20%	30%
OUTPATIENT: Facility Based Care (preauth required)	0%	20%	20%	20%	30%
OTHER SERVICES					
Acupuncture - ***Limits apply***	0%	20%	20%	20%	30%
Ambulance (Ground or Air)	$100 co-pay	$100 co-pay	$100 co-pay + 20%	$100 co-pay + 20%	$100 co-pay + 30%
Chiropractic - ***Limits apply***	0%	20%	20%	20%	30%
Durable Medical Equipment (DME)	0%	20%	20%	20%	30%
Physical and Occupational Therapy - ***Limits apply***	0%	20%	20%	20%	30%
PHARMACY BENEFITS	**5-20**	**200/10-35**	**200/10-35**	**200/15-50**	**30%**
Individual/Family Brand & Specialty Rx Deductibles	None	$200/$500	$200/$500	$200/$500	30%
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	30%
Generic co-pay/30 days supply	$0 at Costco $5 at Other	$5 at Costco $10 at Other	$5 at Costco $15 at Other	$5 at Costco $15 at Other	Deductible + $9
Brand co-pay/30 days supply	$20	$50	$50	$50	Deductible + $35
Specialty co-pay/up to 30 days supply	Must Use Navitus Mail $20	Must Use Navitus Mail $35	Must Use Navitus Mail $50	Must Use Navitus Mail $50	30%
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50	$15-$135	$15-$135	$15-$135	$0
VISION BENEFITS	**Same for all Plans**				NO VISION
VSP PLAN B **0772124A**	Exam/Lenses-12 mos Frames 24 mos Co-pays Exam $15 Materials $25				
DENTAL BENEFITS	**Choose One**				NO DENTAL
Delta Dental - 100% **7074-7112**	Coverage 100% In-Network, 50% Out of Newtork, **Includes Orthodontia** $2,000 max pp per year In Network, $1,000 pp Out of Network				
Delta Dental - Incentive **7074-7012**	70% to start advances to 100% -- No Orthodontia $1200 max pp per year In Network, $1,000 Out of Network				
Anthem Dental **4D004A 75457BA**	LIMITED PROVIDER LIST : $4,000 max pp per year in Network, $ 0.00 Deductible, $2,000 annual implant Max, $2,000 Lifetime Ortho				