PRJUSD Healthcare Plans	40311 F	40312H	40311J	40312A	70312B
CLASSIFIED	90-C $20	90-E $20	80-E $20	80-M $40	**70 /2-Tier**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$200/$500	$300/$600	$300/$600	$3,000/$6,000	$5000/$10,000
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$4,000/$8,000	$6,350/$12,700
PROFESSIONAL SERVICES					
Office Visit (OV) co-pay	$30	$20	$20	$40	30%
Urgent Care co-pay	$30	$20	$20	$40	30%
Specialists/Consultants co-pay	$30	$20	$20	$40	30%
Prenatal, postnatal office visit co-pay	$30	$20	$20	$40	30%
Scans: CT, CAT, MRI, PET etc.	10%	10%	20%	20%	30%
Diagnostic X-ray & Laboratory Procedures	10%	10%	20%	20%	30%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered	No Covered
Preventive Care (includes 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)	10% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay	$100 co-pay + 30%
Inpatient Hospital (preauthorization required)	10%	10%	20%	20%	30%
Outpatient Hospital	10%	10%	20%	20%	30%
Surgery, Outpatient (performed in Surgery Center)	10%	10%	20%	20%	30%
Surgery, Outpatient (performed in a Hospital)	10%	10%	20%	20%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT					
INPATIENT: Facility Based Care (preauth required)	10%	10%	20%	20%	30%
OUTPATIENT: Facility Based Care (preauth required)	10%	10%	20%	20%	30%
OTHER SERVICES					
Acupuncture - Limits apply	10%	10%	20%	20%	30%
Ambulance (Ground or Air)	10% $100 co-pay	10% $100 co-pay	20% $100 co-pay	20% $100 co-pay	$100 co-pay + 30%
Chiropractic - Limits apply	10%	10%	20%	$0	30%
Durable Medical Equipment (DME)	10%	10%	20%	20%	30%
Physical and Occupational Therapy - Limits apply	10%	10%	20%	20%	30%
PHARMACY BENEFITS	**90-35**	**90-35**	**90-35**	**9-35**	**30%**
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	30%
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	30%
Generic co-pay/30 days supply	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network	$0 at Costco $9 at Other Network	Deductible + $9
Brand co-pay/30 days supply	$35	$35	$35	$35	Deductible + $35
Specialty co-pay/up to 30 days supply	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	$0
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$90	$0-$90	$0-$90	$0-$90	$0
VISION BENEFITS	***Same for all Plans***				***NO VISION***
VSP PLAN B **0772123A**	Exam/Lenses-12 mos Frames 24 mos Co-pays Exam $15 Materials $25				
DENTAL BENEFITS	**Choose One**				**NO DENTAL**
Delta Dental - 100%	Coverage 100% In-Network, Outside Network 50% includes				
7074-7511	Orthodontia $3,000 max per person per year, $1,000 out of network				
Delta Dental - Incentive	70% to start advances to 100%, No Orthodontia				
7074-7311	$2,200 max pp per year, In Network - $2,000 pp Out of Network				
Anthem Dental	LIMITED PROVIDER LIST : $4,000 max pp per year in Network, $ 0.00				
4D004A 75457BA	Deductible, $2,000 annual implant Max, $2,000 Lifetime Ortho				