PRJUSD Healthcare Plans	40312D	40311K	40312G	40312E	70312B
MANAGEMENT--CONFIDENTIAL	100-A $20	90-C $20	80-G $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	$0/$0	$200/$500	$500/$1,000	$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	$2,000/$4,000	$4,000/$8,000	$6,350/$12,700
PROFESSIONAL SERVICES					
Office Visit (OV) co-pay	$20	$30	$20	$40	30%
Urgent Care co-pay	$20	$30	$20	$40	30%
Specialists/Consultants co-pay	$20	$30	$20	$40	30%
Prenatal, postnatal office visit co-pay	$20	$30	$20	$40	30%
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	20%	30%
Diagnostic X-ray & Laboratory Procedures	0%	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)	0% / $100 co-pay	10% /$100 co-pay	20% /$100 co-pay	20% /$100 co-pay	$100 co-pay + 30%
Inpatient Hospital (preauthorization required)	0%	10%	20%	20%	30%
Outpatient Hospital	0%	10%	20%	20%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	20%	30%
Surgery, Outpatient (performed in a Hospital)	0%	10%	20%	20%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT					
INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	20%	30%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	20%	30%
OTHER SERVICES					
Acupuncture - Limits apply	0%	10%	20%	20%	30%
Ambulance (Ground or Air)	0% $100 co-pay	$100 co-pay +10%	$100 co-pay + 20%	$100 co-pay + 20%	$100 co-pay + 30%
Chiropractic - Limits apply	0%	10%	20%	$0	30%
Durable Medical Equipment (DME)	0%	10%	20%	20%	30%
Physical and Occupational Therapy - Limits apply	0%	10%	20%	20%	30%
PHARMACY BENEFITS	***5-20***	***9-35***	***9-35***	***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)	$1,500/ $2,500	$2,500/ $3,500	$2,500/ $3,500	$2,500/ $3,500	30%
Generic co-pay/30 days supply	$0-Costco $5-Other	$0-Costco $9-Other	$0-Costco $9-Other	$0-Costco $9-Other	Deductible + $ 9
Brand co-pay/30 days supply	$20	$35	$35	$35	Deductible + $35
Specialty co-pay/up to 30 days supply	Navitus Mail $20	Navitus Mail $35	Navitus Mail $35	Navitus Mail $35	$0
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50	$0-$90	$0-$90	$0-$90	
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%	Coverage 100% In-Network, Outside Network 50% **includes Orthodontia**				
7074-7112	$2,000 max pp per year In Network, $1,000 Out of Network				
Delta Dental - Incentive	70% to start advances to 100% In-Network, No Orthodontia				
7074-7012	$1200 max pp per year In Network, $1,000 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				
LIFE INSURANCE	***All plans include a $100,000 Life Insurance Policy***				