PPO PLANS	PPO 100%	PPO 90%	PPO 80%
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	See PPO Options page	See PPO Options page	See PPO Options page
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	See PPO Options page	See PPO Options page	See PPO Options page
PROFESSIONAL SERVICES			
Office Visit co-pay	See PPO Options page	See PPO Options page	See PPO Options page
Urgent Care co-pay	See PPO Options page	See PPO Options page	See PPO Options page
Specialists/Consultants co-pay	See PPO Options page	See PPO Options page	See PPO Options page
Prenatal, postnatal office visit co-pay	See PPO Options page	See PPO Options page	See PPO Options page
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	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
Inpatient Hospital co-pay (preauthorization required)	0%	10%	20%
Outpatient Hospital co-pay	0%	10%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	0%	10%	20%
Surgery, Outpatient (performed in a Hospital)	0%	10%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT			
INPATIENT CARE: Facility based care (preauthorization required)	0%	10%	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
OTHER SERVICES			
Acupuncture - Limits apply	0%	10%	20%
Ambulance (Ground or Air)	0%	10%	20%
Chiropractic - Limits apply	0%	10%	20%
Durable Medical Equipment (DME)	0%	10%	20%
Physical and Occupational Therapy - Limits apply	0%	10%	20%
PRESCRIPTION DRUG PLANS			
Generic co-pay/days supply	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart
Brand co-pay/days supply	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart
Mail Order (Generic-Brand co-pay/days supply)	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart	See Prescription Drug Plan Chart

NOTATIONS:

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OOP maximum on Anthem and Blue Shield plans with a Navitus pharmacy carve out does not include prescription drug co-pays.

Minimum Value Plans, Health Savings Account Plans and Kaiser HMO or HDHP OOP maximum does 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) with the exception of any Health Savings Account (HSA) plan or Kaiser HDHP plans

The district may not partially pay reimburse or otherwise reduce the member's OOP responsibility unless they contribute to a Health Savings Account (HSA) for the employee.

For plans with a deductible, co-insurance applies after the deductible has been met unless otherwise noted.

PPO Options

Calendar Year Deductibles, Out-of-Pocket Maximum (OOP) and Co-pays

100% Plans	100-A $10	100-A $20	100-B $20	100-C $20
Individual/Family Deductible	$0/$0	$0/$0	$100/$300	$200/$400
Individual/Family OOP Max	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000
Office Visit Copay	$10	$20	$20	$20

100% Plans	100-D $20	100-G $30
Individual/Family Deductible	$300/$600	$500/$1,000
Individual/Family OOP Max	$1,000/$3,000	$1,000/$3,000
Office Visit Copay	$20	$30

90% Plans	90-A $20	90-C $30	90-G $20
Individual/Family Deductible	$100/$300	$200/$500	$500/$1,000
Individual/Family OOP Max	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000
Office Visit Copay	$20	$30	$20

80% Plans	80-C $20	80-E $20	80-G $20	80-G $30
Individual/Family Deductible	$200/$500	$300/$600	$500/$1,000	$500/$1,000
Individual/Family OOP Max	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$2,000/$4,000
Office Visit Copay	$20	$20	$20	$30

80% Plans	80-J $30	80-K $30	80-L $30	80-M $40
Individual/Family Deductible	$750/$1,500	$1,000/$2,000	$2,000/$4,000	$3,000/$6,000
Individual/Family OOP Max	$3,000/$6,000	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000
Office Visit Copay	$30	$30	$30	$40

NOTATIONS:

Calendar Year Out-of-Pocket Maximums includes plan co-pays, deductible and co-insurance for in-network and emergency service.

Medical OOP Maximums shown are for medical plans only. See Prescription Drug page for applicable pharmacy OOP Maximums.

PPO PLANS	HSA-A PLAN	HSA-B PLAN	MINIMUM VALUE	ANCHOR BRONZE
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$1,500/$3,000	$3,000/$5,000	$5,000/$10,000	$5,000/$10,000
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$4,000/$8,000	$5,000/$10,000	$6,350/$12,700	$6,350/$12,700
PROFESSIONAL SERVICES				
Office Visit co-pay	10%	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Urgent Care co-pay	10%	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Specialists/Consultants co-pay	10%	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Prenatal, postnatal office visit co-pay	10%	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Scans: CT, CAT, MRI, PET etc.	10%	10%	30%	30%
Diagnostic X-ray & Laboratory Procedures	10%	10%	30%	30%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit co-pay (waived if admitted)	10% $100 co-pay	10% $100 co-pay	30% $100 co-pay	30% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	10%	10%	30%	30%
Outpatient Hospital co-pay	10%	10%	30%	30%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	10%	10%	30%	30%
Surgery, Outpatient (performed in a Hospital)	10%	10%	30%	30%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT				
INPATIENT CARE: Facility based care (preauthorization required)	10%	10%	30%	30%
OUTPATIENT CARE: Facility based care (preauthorization required)	10%	10%	30%	30%
OTHER SERVICES				
Acupuncture - Limits apply	10%	10%	30%	30%
Ambulance (Ground or Air)	10%	10%	30%	30%
Chiropractic - Limits apply	10%	10%	30%	30%
Durable Medical Equipment (DME)	10%	10%	30%	30%
Physical and Occupational Therapy - Limits apply	10%	10%	30%	30%
PRESCRIPTION DRUG PLANS				
Generic co-pay/days supply	After deductible, $7/ 30-day	After deductible, $7/ 30-day	After deductible, $9/ 30-day	After deductible, $9/ 30-day
Brand co-pay/days supply	After deductible, $25/30-day	After deductible, $25/30-day	After deductible, $35/30-day	After deductible, $35/30-day
Mail Order (Generic-Brand co-pay/days supply)	After deductible, $14-25/90-day	After deductible, $14-25/90-day	After deductible, $18-90/90-day	After deductible, $18-90/90-day

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OOP maximum on Anthem and Blue Shield plans with a Navitus pharmacy carve out does not include prescription drug co-pays.

Minimum Value Plans, Health Savings Account Plans and Kaiser HMO or HDHP OOP maximum does 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) with the exception of any Health Savings Account (HSA) plan or Kaiser HDHP plans

The district may not partially pay reimburse or otherwise reduce the member's OOP responsibility unless they contribute to a Health Savings Account (HSA) for the employee.

For plans with a deductible, co-insurance applies after the deductible has been met unless otherwise noted.

Prescription Drug Plans
2015-16

>> Free Generic Drugs at Costco as well as through Mail Order <<
(In 2014, 80% of prescriptions were filled with Generic Drugs)

Costco Pharmacies are open to non-members.

PLAN	5-20				
	Walk-in			Mail	
	Network	Costco		Costco	Navitus
Days Supply	30	30	90	90	30
Generic	$5	**Free**	**Free**	**Free**	
Brand	$20	$20	$50	$50	
Specialty ‡					$20
Out-of-Pocket Maximum	$1,500 Individiual / $2,500 Family				

PLAN	7-25				
	Walk-in			Mail	
	Network	Costco		Costco	Navitus
Days Supply	30	30	90	90	30
Generic	$7	**Free**	**Free**	**Free**	
Brand	$25	$25	$60	$60	
Specialty ‡					$25
Out-of-Pocket Maximum	$1,500 Individiual / $2,500 Family				

9-35				
Walk-in			Mail	
Network	Costco		Costco	Navitus
30	30	90	90	30
$9	**Free**	**Free**	**Free**	
$35	$35	$90	$90	
				$35
$2,500 Individiual / $3,500 Family				

PLAN	200/10-35				
	Walk-in			Mail	
	Network	Costco		Costco	Navitus
Days Supply	30	30	90	90	30
Brand/Specialty Deductible*	$200 Individiual / $500 Family				
Generic	$10	**Free**	**Free**	**Free**	
Brand	$35	$35	$90	$90	
Specialty ‡					$35
Out-of-Pocket Maximum	$2,500 Individiual / $3,500 Family				

200/15-50				
Walk-in			Mail	
Network	Costco		Costco	Navitus
30	30	90	90	30
$200 Individiual / $500 Family				
$15	**$5**	**$15**	**$15**	
$50	$50	$135	$135	
				$50
$2,500 Individiual / $3,500 Family				

*Rx plans on this page with a deductible include fourth quarter carryover. Once the deductible has been satisfied, the member will be responsible for the brand name co-pay.

‡ Drugs designated as Specialty Drugs are only available in 30 day supplies through the mail from Navitus.

>> Free Generic Drugs at Costco as well as through Mail Order <<

The $200/$15-$50 Rx Plan features reduced generic copays at Costco (not free).
Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.
Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.

Generic Co-Pays for Lancets and Syringes.
Generic Co-Pays for Test Strips manufactured by Abbott (Freestyle) and Lifescan (One Touch)

Diabetic supplies are only available as brand prescriptions and not generic. However, the SISC pharmacy plans charge the generic co-pay for Lancets and Syringes. In addition, SISC pharmacy plans charge the generic co-pay on Test Strips manufactured by Abbott (Freestyle) and Lifescan (One touch). Effective October 1, 2015, the brand co-pay will be charged for all test strips from other manufacturers.

KAISER PERMANENTE HMO PLANS	Kaiser Traditional HMO $10/$10	Kaiser Traditional HMO $20/$10-$20	Kaiser Traditional HMO $30/$10-$30	Kaiser Deductible HMO $500 Hospital ONLY	Kaiser Deductible HMO $1,000 Hospital ONLY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOP)	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0	$0	$0	$500/$1,000	$1,000/$2,000
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000
PROFESSIONAL SERVICES					
Office Visit co-pay	$10	$20	$30	$20	$20
Urgent Care co-pay	$10	$20	$30	$20	$20
Specialists/Consultants co-pay	$10	$20	$30	$20	$20
Prenatal, postnatal office visit co-pay	$0	$0	$0	$0	$0
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	$50	$50
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	$10	$10
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	50%	50%	50%
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0	$0, Ded Waived	$0, Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit co-pay (waived if admitted)	$100	$100	$100	10%	20%
Inpatient Hospital co-pay (preauthorization required)	$0	$0	$0	10%	20%
Outpatient Hospital co-pay	$10	$20	$30	10%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$10	$20	$30	10%	20%
Surgery, Outpatient (performed in a Hospital)	$10	$20	$30	10%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					
INPATIENT CARE: Facility based care (preauthorization required)	$0	$0	$0	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	$10	$20	$30	10%	20%
OTHER SERVICES					
Acupuncture - Limits apply	$10/30 visits	$10/30 visits	$10/30 visits	$10/30 visits	$10/30 visits
Ambulance (Ground or Air)	$50	$50	$50	$150	$150
Chiropractic - Limits apply	$10/30 visits	$10/30 visits	$10/30 visits	$10/30 visits	$10/30 visits
Durable Medical Equipment (DME)	100%	100%	100%	20%	20%
Physical and Occupational Therapy - Limits apply	$10	$20	$30	$20	$20
PRESCRIPTION DRUG PLANS					
Generic co-pay/days supply	$10/100-day	$10/100-day	$10/100-day	$10/30-day	$10/30-day
Brand co-pay/days supply	$10/100-day	$20/100-day	$30/100-day	$30/30-day	$30/30-day
Mail Order (Generic-Brand co-pay/days supply)	$10/100-day	$10-20/100-day	$10-30/100-day	$10-30/30-day	$10-30/30-day

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