SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

	PBC 80-E $30, RX $7-$25		PBC 80-G $30, RX $7-$25		HSA-A		HSA-B		2-Tier Anchor Bronze	
Provider Network(s):										
Hospital	**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**	
Professional	**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**		**Prudent Buyer**	
Calendar Year Deductible(s)	**$300** per individual up to **$600** per family		**$500** per individual up to **$1,000** per family		**$1,300** per individual up to **$2,600** per family		**$2,500** per individual up to **$5,000** per family		**$5,000** per individual up to **$10,000** per family	
Calendar Year Out of Pocket Maximum	**$1,000** per individual up to **$3,000** per family		**$2,000** per individual up to **$4,000** per family		**$5,000** per individual up to **$10,000** per family		**$6,350** per individual up to **$12,700** per family		**$6,350** per individual up to **$12,700** per family	
Co-insurance is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%).	This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 20% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 10% co-insurance.		This plan's Annual Out of Pocket Maximum includes the member's deductible, co-pays and 30% co-insurance.	
Services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Office Visits	Deductible Waived $30 co-pay	Non-Par Fee	Deductible Waived $30 co-pay	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	$60 first 3 visits, subject to deductible and coinsurance thereafter	Non-Par Fee
Inpatient Hospital Room, Board & Support Services (prior authorization required)	80%	$600 per day	80%	$600 per day	90%	$600 per day	90%	$600 per day	70%	$600 per day
Ambulatory Surgery Center	80%	$350 per admit	80%	$350 per admit	90%	$350 per admit	90%	$350 per admit	70%	$350 per admit
Emergency Room (non-emergency)	$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay	
Facility Expenses:	80%	50% C&R	80%	50% C&R	90%	50% C&R	90%	50% C&R	70%	50% C&R
Professional Expenses:	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Accident Care (48 hrs)/**Emergency Room***	$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay		$100 co-pay	
Facility Expenses:	80%	80% C&R	80%	80% C&R	90%	90% C&R	90%	90% C&R	70%	70% C&R
Professional Expenses: *medical emergencies as defined by the plan	80%	80% C&R	80%	80% C&R	90%	90% C&R	90%	90% C&R	70%	70% C&R
Surgeon & Anesthetist	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Preventive Care Services (Adults & Children - All Ages) Including physical exams and preventive screenings	**Deductible Waived 100%**	**Not Covered**	**Deductible Waived 100%**	**Not Covered**	**Deductible Waived 100%**	**Not Covered**	**Deductible Waived 100%**	**Not Covered**	**Deductible Waived 100%**	**Not Covered**
Diagnostic X-Ray & Lab MRI, CT, PET & nuclear cardiac scan (UR)	80%	Non Par Fee up to $800	80%	Non Par Fee up to $800	90%	Non Par Fee up to $800	90%	Non Par Fee up to $800	70%	Non Par Fee up to $800
Other diagnostic x-ray & lab	80%	Non Par Fee	80%	Non Par Fee	90%	Non Par Fee	90%	Non Par Fee	70%	Non Par Fee
Physical Medicine (OT, PT, Chiro) (some limits may apply)	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Speech Therapy	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Acupuncture 12 visits per year	80%	Non-Par Fee up to $25 per visit	80%	Non-Par Fee up to $25 per visit	90%	Non-Par Fee up to $25 per visit	90%	Non-Par Fee up to $25 per visit	70%	Non-Par Fee up to $25 per visit
Durable Medical Equipment										
Rental or Purchase of DME	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Hearing Aid ($700 maximum every 24 months)	80%	Non-Par Fee	80%	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	70%	Non-Par Fee
Hospice	100%	100% allowed amount	100%	100% allowed amount	100%	100% allowed amount	100%	100% allowed amount	100%	100% allowed amount
Ambulance (Ground or Air)	80%	80% C&R	80%	80% C&R	90%	90% C&R	90%	90% C&R	70%	70% C&R
Home Health Care 100 4-hour visits/yr (prior authorization req'd)	80%	Non-Par Fee	80%	Non-Par Fee	90%	90% Non-Par Fee	90%	90% Non-Par Fee	70%	70% Non-Par Fee
Home Infusion	80%	100% up to $600/day	80%	100% up to $600/day	90%	100% up to $600/day	90%	100% up to $600/day	70%	100% up to $600/day
Psychiatric & Substance Abuse										
Inpatient	80%	$600 per day	80%	$600 per day	90%	$600 per day	90%	$600 per day	70%	$600 per day
Outpatient Professional	Deductible Waived $30 co-pay	Non-Par Fee	Deductible Waived $30 co-pay	Non-Par Fee	90%	Non-Par Fee	90%	Non-Par Fee	$60 first 3 visits, subject to deductible and coinsurance thereafter	Non-Par Fee
Outpatient Prescription Drugs					**Anthem Rx Plan**		**Anthem Rx Plan**		**Anthem Rx Plan**	
	Retail 30 days	**Mail** 90 days	**Retail** 30 days	**Mail** 90 days	**Retail** 30 days	**Mail** 90 days	**Retail** 30 days	**Mail** 90 days	**Retail** 30 days	**Mail** 90 days
Supply	Not applicable		Not applicable		Subject to medical deductible		Subject to medical deductible		Subject to medical deductible	
Brand Name Calendar Year Deductible										
Generic Drugs	$7	$14*	$7	$14*	$7	$14	$7	$14	$9	$18
Brand Name Drugs	$25	$60	$25	$60	$25	$60	$25	$60	$35	$90

***Some generic medications qualify for a zero copayment through the Costco Pharmacy Mail Order.**

Deductible accumulator does not have 4th quarter carryover.

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This is a brief summary of benefits. For details, limitations and exclusion, please refer to the Summary Plan Description.

"Note: The "or" is because of gov.regs that require at least a $2,500 family dedcutible be satisified on a two party or family policy. On a single contract, the single person only needs to satisfy the deductible of $1,250 before the plan will pay at 90%. All enrollees will be subject to the plan design based on Federal guidelines.

RATES	**PBC 80-E $30, RX $7-$25** **DELTA DENTAL** **ORTHO** **VSP** **LIFE**	**PBC 80-G $30, RX $7-$25** **DELTA DENTAL** **ORTHO** **VSP** **LIFE**	**HSA-A** **DELTA DENTAL** **ORTHO** **VSP** **LIFE**	**HSA-B** **DELTA DENTAL** **ORTHO** **VSP** **LIFE**	**2-Tier Anchor Bronze** **DELTA DENTAL** **ORTHO** **VSP** **LIFE**
TOTAL PER EMP/MO	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL PER EMP/YR	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
%INCREASE CURRENT YR					
DISTRICT CONTRIBUTION					
DIFFERENCE PER EMP/YR	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
DIFFERENCE PER EMP/MO (12)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**