GRANDFATHERED—TEAMSTERS I RATES 2019 – 2020

PSUSD contributes towards the cost of the benefit package according to your Cap or hours worked per day. The employee pays any benefits package costs over this amount in 11 months payroll deductions using pre-tax dollars:

EMPLOYEE DEDUCTIONS - 11 MONTHLY DEDUCTIONS (Rates include employee + dependents)

	Dental Plan Selected	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
4 HRS (50%) Cap: $7,798.00	11 MONTH + DELTA INCENTIVE PPO	$701.33	$701.33	$701.33
	11 MONTH + DELTA PPO	$694.11	$694.11	$694.11
	11 MONTH + DELTACARE DHMO	$649.31	$649.31	$649.31
5 HRS (65%) Cap: $10,137.40	11 MONTH + DELTA INCENTIVE PPO	$631.62	$631.62	$631.62
	11 MONTH + DELTA PPO	$617.19	$617.19	$617.19
	11 MONTH + DELTACARE DHMO	$527.58	$527.58	$527.58
6 HRS (75%) Cap: $11,697.00	11 MONTH + DELTA INCENTIVE PPO	$489.84	$489.84	$489.84
	11 MONTH + DELTA PPO	$475.41	$475.41	$475.41
	11 MONTH + DELTACARE DHMO	$385.80	$385.80	$385.80

	Medical Plan Features	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
	Calendar Year Maximum	Unlimited	Unlimited	Unlimited
	Deductible (Annual) - Individual/ Family	None	None	$500 / $1,500
	Co-Insurance (Plan Pays)	100%	100%	80%
	Office Visit Copay - Primary Physician / Specialist	$10 / $10	$10 / $15	Ded, then 20%
	Out-of-Pocket Maximum - Individual / Family / Prescription	$1,500 / $3,000	$2,000 / $6,000	Medical: $2,000 / $6,000 Prescription: $1,200
	Inpatient Hospitalization	No charge	No charge	Ded, then 20%
	Outpatient Diagnostic Tests	No charge	No charge	Ded, then 20%
	Emergency Services (Copay waived if admitted)	$100 Copay	$100 Copay	Ded, then 20%
	Urgent Care Copay	$10	$50	Ded, then 20%
	Preventive Care/Screening	No charge	No charge	No charge
	Mental Health/Substance Abuse - Outpatient Services - Inpatient Services	$10 (individual visit)/$5 (group visit) No charge	Provided by HMC $10 Copay No charge	Provided by HMC Ded, then 20% Ded, then 20%
	Chiropractic Copay/Visits per Yr.	Not covered	$15 / limits may apply	Ded, then 20% / 40 visits

PRESCRIPTION PLAN FEATURES—ALL ANTHEM BLUE CROSS DRUG PRESCRIPTION PLANS ARE ADMINISTERED BY OPTUMRx

	Prescription Drugs Plan	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
	Retail Pharmacy - Generic/Brand/Non-Formulary - Supply Limit	$10/$15 Up to 100-day supply	$10/$15/$30 Up to 30-day supply	$10/$15/$15 Up to 30-day supply
	Mail Order Pharmacy - Generic/Brand/Non-Formulary - Supply Limit	$10/$15 Up to 100-day supply	$10/$20/$35 Up to 90-day supply	$10/$20/$35 Up to 90-day supply

GRANDFATHERED—TEAMSTERS II RATES 2019 – 2020

PSUSD contributes towards the cost of the benefit package according to your Cap or hours worked per day. The employee pays any benefits package costs over this amount in 12 months payroll deductions using pre-tax dollars:

EMPLOYEE DEDUCTIONS - 12 MONTHLY DEDUCTIONS (Rates include employee + dependents)

	Dental Plan Selected	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
4 HRS (50%) Cap: $7,798.00	12 MONTH + DELTA INCENTIVE PPO	$642.89	$642.89	$642.89
	12 MONTH + DELTA PPO	$636.27	$636.27	$636.27
	12 MONTH + DELTACARE DHMO	$595.20	$595.20	$595.20
5 HRS (65%) Cap: $10,137.40	12 MONTH + DELTA INCENTIVE PPO	$578.99	$578.99	$578.99
	12 MONTH + DELTA PPO	$565.76	$565.76	$565.76
	12 MONTH + DELTACARE DHMO	$483.62	$483.62	$483.62
6 HRS (75%) Cap: $11,697.00	12 MONTH + DELTA INCENTIVE PPO	$449.02	$449.02	$449.02
	12 MONTH + DELTA PPO	$435.79	$435.79	$435.79
	12 MONTH + DELTACARE DHMO	$353.65	$353.65	$353.65

Medical Plan Features	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
Calendar Year Maximum	Unlimited	Unlimited	Unlimited
Deductible (Annual) - Individual/ Family	None	None	$500 / $1,500
Co-Insurance (Plan Pays)	100%	100%	80%
Office Visit Copay - Primary Physician / Specialist	$10 / $10	$10 / $15	Ded, then 20%
Out-of-Pocket Maximum - Individual / Family / Prescription	$1,500 / $3,000	$2,000 / $6,000	Medical: $2,000 / $6,000 Prescription: $1,200
Inpatient Hospitalization	No charge	No charge	Ded, then 20%
Outpatient Diagnostic Tests	No charge	No charge	Ded, then 20%
Emergency Services (Copay waived if admitted)	$100 Copay	$100 Copay	Ded, then 20%
Urgent Care Copay	$10	$50	Ded, then 20%
Preventive Care/Screening	No charge	No charge	No charge
Mental Health/Substance Abuse - Outpatient Services - Inpatient Services	$10 (individual visit)/$5 (group visit) No charge	Provided by HMC $10 Copay No charge	Provided by HMC Ded, then 20% Ded, then 20%
Chiropractic Copay/Visits per Yr.	Not covered	$15 / limits may apply	Ded, then 20% / 40 visits

PRESCRIPTION PLAN FEATURES—ALL ANTHEM BLUE CROSS DRUG PRESCRIPTION PLANS ARE ADMINISTERED BY OPTUMRx

Prescription Drugs Plan	Kaiser HMO Plan	Anthem Blue Cross HMO	Anthem Blue Cross PPO
Retail Pharmacy - Generic/Brand/Non-Formulary - Supply Limit	$10/$15 Up to 100-day supply	$10/$15/$30 Up to 30-day supply	$10/$15/$15 Up to 30-day supply
Mail Order Pharmacy - Generic/Brand/Non-Formulary - Supply Limit	$10/$15 Up to 100-day supply	$10/$20/$35 Up to 90-day supply	$10/$20/$35 Up to 90-day supply