

HEALTH INSURANCE

2023-2024 OPEN ENROLLMENT



Review 2023-24 plans and rates

Review rates and compare plans using the information in this Open Enrollment Packet and the Open Enrollment email that states your current plan selections.



Meet with vendors for medical, dental, and vision insurance to learn more about value added benefits, plan changes, and more.

Make changes if needed

If you would like to make a change, please notify Payroll by August 31st. We will provide you the appropriate forms.

Changes take effect October 1st

On September 30th, new rates will be reflected on your paycheck. All plan changes will be effective on October 1st. 04

PAYROLL@RIPONUSD.NET

For changes or questions, please use our payroll email or call 209-599-2131



FRIDAY, AUG 4TH, 2023 | 9:45 AM - 12:00 PM RIPON HIGH ABEYTA-HORTIN GYM

- MEET WITH INSURANCE AND BENEFIT VENDORS - MEET WITH OTHER LOCAL BUSINESSES - ENTER TO WIN RAFFLE PRIZES!

IF YOU DO NOT TAKE DISTRICT HEALTH INSURANCE, WE INVITE YOU TO STOP BY AND LEARN ABOUT OTHER VOLUNTARY DEDUCTIONS

Full-Time

SISC Health Insurance Rates

Plan Year: October 2023 - September 2024

Effective: 10/1/2023 (9/30/23 Paycheck)

Full Time Employee (1.0 FTE) Total Annual Di ANTHEM 100% - PLAN A S0 Deductibi \$1,000/\$3,000 Max Out of Pocke 40346i	 Dist CAP employee cost 	Employee 637.70 7,652.40 Employee \$1,244.00 \$637.70	*aid Contribution/ Employee +1 896.53 10,758.36 Employee +1 \$2,140.00	Family 1,066.16 12,793.92 Family	Calculate Your Monthly Cost
ANTHEM 100% - PLAN / \$0 Deductibl \$1,000/\$3,000 Max Out of Pocke	A Premium t Dist CAP a employee cost	637.70 7,652.40 Employee \$1,244.00 \$637.70	896.53 10,758.36 Employee +1	1,066.16 12,793.92 Family	
ANTHEM 100% - PLAN / \$0 Deductibl \$1,000/\$3,000 Max Out of Pocke	A Premium t Dist CAP a employee cost	7,652.40 Employee \$1,244.00 \$637.70	10,758.36 Employee +1	12,793.92 Family	
\$0 Deductibl \$1,000/\$3,000 Max Out of Pocke	 Dist CAP employee cost 	\$1,244.00 \$637.70	Employee +1	Family	
\$0 Deductibl \$1,000/\$3,000 Max Out of Pocke	 Dist CAP employee cost 	\$637.70	\$2,140.00		
\$1,000/\$3,000 Max Out of Pocke	t Dist CAP employee cost			\$2,715.00	
40346	employee cost	¢606.20	\$896.53	\$1,066.16	
	Bromium	\$606.30	\$1,243.47	\$1,648.84	
ANTHEM 80% - PLAN (\$500/\$1,000 Deductibl		\$946.00	\$1,628.00	\$2,065.00	
\$2,000/\$4,000 Max Out of Pocke		\$637.70	\$896.53	\$1,066.16	
40346	employee cost	\$308.30	\$731.47	\$998.84	
ANTHEM 80% - PLAN \$2,000/\$4,000 Deductibl		\$823.00	\$1,416.00	\$1,797.00	
\$4,000/\$8,000 Max Out of Pocke		\$637.70	\$896.53	\$1,066.16	
40346	employee cost	\$185.30	\$519.47	\$730.84	
ANTHEM 90% - PLAN HSA (HDHP \$3,000/\$5,200 Deductibl		\$752.00	\$1,293.00	\$1,642.00	
\$5,000/\$10,000 Max Out of Pocke	t Dist CAP	\$637.70	\$896.53	\$1,066.16	
40346	employee cost	\$114.30	\$396.47	\$575.84	
KAISER HMO Traditional Plan \$0 Deductibl		\$982.00	\$1,688.00	\$2,140.00	
\$1,500/\$3,000 Max Out of Pocke	t Dist CAP	\$637.70	\$896.53	\$1,066.16	
606394-0069ALI	employee cost	\$344.30	\$791.47	\$1,073.84	
KAISER HDHP \$1,500/\$3,000 Deductibl		\$787.00	\$1,354.00	\$1,717.00	
\$3,000/\$6,000 Max Out of Pocke		\$637.70	\$896.53	\$1,066.16	
606394-0102AL	employee cost	\$149.30	\$457.47	\$650.84	
2-TIER HS/ formerly ANTHEM 70% BRONZ	E				
PLAN \$5,000/\$10,000 Deductibl		\$683.00	N/A	\$1,161.00	
\$6,350/\$12,700 Max Out of Pocke	t Dist CAP	\$637.70		\$1,066.16	
70109	³ employee cost	\$45.30		\$94.84	
WABE - Medical OPT OU (No Medical Coverage		\$683.00 \$637.70	N/A	N/A	
WABE68650		\$45.30			
WADLOBUSU		<i>Q45</i> .555			
Delta Dental Premie	r employee cost	\$93.00	\$93.00	\$93.00	
Build Coverage 70%-100% 7086-211)				
Delta Dental Preferred Most Services 100% Covered 7086-311		\$85.00	\$85.00	\$85.00	
VSI 3237445/		\$23.60	\$23.60	\$23.60	
52574457	`		Total emplo	yee selection	\$
			x 12 mos/	11 paychecks	\$

Waiver of Anchor Bronze Enrollment – WABE: The purpose of RUSD offering this enrollment option is so employees with secondary coverage will not have issues accessing their secondary coverage (which will become primary for employee in WABE). The WABE program is premium in lieu of enrollment. Employees that choose WABE will not have medical or prescription drug coverage, they will have MDLIVE, EAP, Advance Medical second opinion and Biometric Screenings coverage. Employees enrolled in WABE must also enroll in the dental and vision plans offered by RUSD. Employees electing the WABE option must also sign a "Declination of Coverage for Full Time Employees form". Please contact Payroll for more information.

Part-Time

SISC Health Insurance Rates

Plan Year: October 2023 - September 2024

Effective: 10/1/2023 (9/30/23 Paycheck)

Part Time Employee (6 hours) M Total Annual District Co ANTHEM 100% - PLAN A S0 Deductible	edical CAP ontribution	Employee 478.28 5,739.30 Employee	aid Contribution/ Employee +1 672.40 8,068.77	Family 799.62 9,595.44	
Total Annual District Co ANTHEM 100% - PLAN A	entribution	5,739.30			
ANTHEM 100% - PLAN A	_		8,068.77	9,595.44	
	_ Premium	Employee			
	Premium		Employee +1	Family	Calculate Your Monthly Cost
SO Deductible		\$1,244.00	\$2,140.00	\$2,715.00	
\$1,000/\$3,000 Max Out of Pocket	Dist CAP	\$478.28	\$672.40	\$799.62	
^{40346B} emp	oloyee cost	\$765.73	\$1,467.60	\$1,915.38	
ANTHEM 80% - PLAN G \$500/\$1,000 Deductible	Premium	\$946.00	\$1,628.00	\$2,065.00	
\$2,000/\$4,000 Max Out of Pocket	Dist CAP	\$478.28	\$672.40	\$799.62	
^{40346C} emp	oloyee cost	\$467.73	\$955.60	\$1,265.38	
ANTHEM 80% - PLAN L \$2,000/\$4,000 Deductible	Premium	\$823.00	\$1,416.00	\$1,797.00	
\$4,000/\$8,000 Max Out of Pocket	Dist CAP	\$478.28	\$672.40	\$799.62	
^{40346D} emp	oloyee cost	\$344.73	\$743.60	\$997.38	
ANTHEM 90% - PLAN HSA (HDHP) \$3,000/\$5,200 Deductible	Premium	\$752.00	\$1,293.00	\$1,642.00	
\$5,000/\$10,000 Max Out of Pocket	Dist CAP	\$478.28	\$672.40	\$799.62	
^{40346F} emp	oloyee cost	\$273.73	\$620.60	\$842.38	
KAISER HMO Traditional Plan \$0 Deductible	Premium	\$982.00	\$1,688.00	\$2,140.00	
\$1,500/\$3,000 Max Out of Pocket	Dist CAP	\$478.28	\$672.40	\$799.62	
606394-0069ALN emp	oloyee cost	\$503.73	\$1,015.60	\$1,340.38	
KAISER HDHP \$1,500/\$3,000 Deductible	Premium	\$787.00	\$1,354.00	\$1,717.00	
\$3,000/\$6,000 Max Out of Pocket 606394-0102ALN	Dist CAP	\$478.28	\$672.40	\$799.62	
emp	oloyee cost	\$308.73	\$681.60	\$917.38	
2-TIER HSA (formerly ANTHEM 70% BRONZE PLAN)	Premium	\$683.00	N/A	\$1,161.00	
\$5,000/\$10,000 Deductible \$6,350/\$12,700 Max Out of Pocket	Dist CAP	\$478.28		\$799.62	
70100P	oloyee cost	\$ 204.73		\$361.38	
WABE - Medical OPT OUT	Premium	\$683.00	N/A	N/A	
(No Medical Coverage)	Dist CAP	\$478.28			
WABE68650L emp	oloyee cost	\$204.73			
				4	
Delta Dental Premier emp Build Coverage 70%-100% 7086-2110	loyee cost	\$93.00	\$93.00	\$93.00	
Delta Dental Preferred emp Most Services 100% Covered 7086-3110	oloyee cost	\$85.00	\$85.00	\$85.00	
VSP emp 3237445A	oloyee cost	\$23.60	\$23.60	\$23.60	
		=	Total employ	yee selection	\$
			x 12 mos/ 1	11 paychecks	\$

Waiver of Anchor Bronze Enrollment – WABE: The purpose of RUSD offering this enrollment option is so employees with secondary coverage will not have issues accessing their secondary coverage (which will become primary for employee in WABE). The WABE program is premium in lieu of enrollment. Employees that choose WABE will not have medical or prescription drug coverage, they will have MDLIVE, EAP, Advance Medical second opinion and Biometric Screenings coverage. Employees enrolled in WABE must also enroll in the dental and vision plans offered by RUSD. Employees electing the WABE option must also sign a "Declination of Coverage for Full Time Employees form". Please contact Payroll for more information.

Ripon Unified School District

This is a limited summary of Medical Plan Benefits for Plan Year October 2023. For detailed coverage refer to the Plan Document and SBC



Offer Visi - Ligent Care - Specialist/Consultants \$10 \$20 \$30 10% 30% \$30 10% After Deductibit 50 Prie & Des Malo Care 0% 20% 20% 10% 30% \$30 10%. After Deductibit 50 Stants CT - CAT - MRI - PTT 0% 20% 20% 10% 30% \$30 10%. After Deductibit 50 Diagnosis: K-ry, RAL baboratory Procedures 0% 20% 20% 10% 30% \$30 10%. After Deductibit Diagnosis: K-ry, RAL baboratory Procedures 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital Crience (Intern Authorization Required) 0% 20% 10% 30% \$30 10%. After Deductibit Durio bit Monitactio							nik Listan Kasala	
Monthy UNIXAUSY Prenum Rate 91,240 91,221 91,221 91,221 91,221 91,221 91,221 91,221 91,221 91,220 91,200 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>								
Manthly FAMILY Pearlian Rate 13,273 52,055 51,147 51,141 52,77 51,847 MEMBER PAYS MEMBER	Monthly SINGLE Premium Rate	\$1,244	\$946	\$823	\$752	\$683	\$982	\$787
NELNIER PAYS MEMBER PAYS MEMBER PAYS MEMBER PAYS MEMBER PAYS MEMBER PAYS PREVENTANCE CASE (Includes Physical Lama & Screening) 50 <t< td=""><td>Monthly DEPENDENT Premium Rate</td><td>\$2,140</td><td>\$1,628</td><td>\$1,416</td><td>\$1,293</td><td></td><td>\$1,688</td><td>\$1,354</td></t<>	Monthly DEPENDENT Premium Rate	\$2,140	\$1,628	\$1,416	\$1,293		\$1,688	\$1,354
PREVENTATIVE CARE (Includes Physical Datam & Screenings) 58 59 50 50 50 50 MEDICAL-CAREMORE YEAR Decidables & Maximum Subjoint	Monthly FAMILY Premium Rate	\$2,715	\$2,065	\$1,797	\$1,642	\$1,161	\$2,140	\$1,717
MEDICAL - CALENDAR YEAR Deductible & Maximums System		MEMBER PAYS	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
Individual/smith Deck Solo	PREVENTATIVE CARE (Includes Physical Exams & Screenings)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
* houdes is individue first individue firs	MEDICAL - CALENDAR YEAR Deductibles & Maximums							
Inducts Media Deductible, Co-Insurance & Co-panyal S1.000/S1.000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S1.000/S0.0000 DefORSIONAL SERVICES S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.00000 S0.000/S1.0000 S0.000 S0.000 S0.000/S1.0000 S0.000/S1.0000 S0.000/S1.0000 S0.000 S0.000 S0.00	* Includes RX	\$0/\$0	\$500/\$1,000	\$2,000/\$4,000	\$3,000/\$5,200*	\$5,000/\$10,000*	\$0/\$0	\$1,500/\$3,000
Offer Visi - Ligent Care - Specialist/Consultants \$10 \$20 \$30 10% 30% \$30 10% After Deductibit 50 Prie & Des Malo Care 0% 20% 20% 10% 30% \$30 10%. After Deductibit 50 Stants CT - CAT - MRI - PTT 0% 20% 20% 10% 30% \$30 10%. After Deductibit 50 Diagnosis: K-ry, RAL baboratory Procedures 0% 20% 20% 10% 30% \$30 10%. After Deductibit Diagnosis: K-ry, RAL baboratory Procedures 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% \$30 10%. After Deductibit Outpatient Hospital Crience (Intern Authorization Required) 0% 20% 10% 30% \$30 10%. After Deductibit Durio bit Monitactio		\$1,000/\$3,000	\$2,000/\$4,000	\$4,000/\$8,000	\$5,000/\$10,000*	\$6,350/\$12,700*	\$1,500/\$3,000	\$3,000/\$6,000
Pres Post Nati Care S00	PROFESSIONAL SERVICES							
Scans: CT - CAT - MRI - PET 0% 20% 20% 20% 10% 30% S0 10% After Deductibil Diagnostic X-ray & Laboratory Procedures 0% 20% 20% 10% 30% 50 10% After Deductibil Magnetic Morphal 0% 20% 20% 10% 30% 50 10% After Deductibil In Patient Hospital 0% 20% 20% 10% 30% 50 10% After Deductibil Outgatest Signer Performed Magnetized 0% 20% 10% 30% 530 10% After Deductibil Outgatest Signer Performed Magnetized 0% 20% 20% 10% 30% 530 10% After Deductibil Emergency Room Visit (Walved if Admitted) 5100 \$100, then 20% \$100, then 20% \$100, then 20% \$100, then 30% \$20 10% After Deductibil Outpatent Site Real Magnetized 0% 20% 20% 10% 30% \$30 10% After Deductibil Outpatent: Site Site Real Magnet Mathematical Cane Marking Magnetized					10%	30%	\$30	10% After Deductible \$0
Diagnostic X-ray & Laboratory Procedures 0% 20% 20% 10% 30% 50 10% After Deductibit In-Patient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% 50 10% After Deductibit Outpatient Hospital (Prior Authorization Required) 0% 20% 20% 10% 30% 50 10% After Deductibit Outpatient Hospital 0% 20% 20% 10% 30% 530 10% After Deductibit Outpatient Hospital Mained Care (Prior Authorization Required) 5100 5100; then 20% 500; then 20% 500; then 30% 530 10% After Deductibit MEMTAL HEALTH & SUBSTANCE ADUST REATMENT In-Patient-Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% 50 10% After Deductibit Outpatient Hospital Gorond or Air) 0% 20% 20% 10% 30% 50 10% After Deductibit Outpatient Hospital Gorond or Air) 0% 20% 20% 10% 30% 510 10% After Dedu	* Primary Care Provider Office Visit Copayment	\$0 Copay for the 1	st three office visits with PC	P in Calendar Year				
HOSPITAL & SKILLED NURSING FACILITY SERVICES No. Contraction Contrest contraction Contraction	Scans: CT - CAT - MRI - PET		20%	20%	10%	30%		10% After Deductible
Im-Patient Hospital (Prior Authonization Required) 0% 20% 20% 10% 30% 50 10% After Deductibit Outpatient Hospital 0% 20% 20% 10% 30% 530 10% After Deductibit Outpatient Hospital 0% 20% 20% 10% 30% 530 10% After Deductibit Outpatient Hospital 0% 20% 20% 10% 30% 500 10% After Deductibit Emergency Room Visk (Wolved / Admitted) 5100 10% After Deductibit 5100 10% After Deductibit Im-Patient Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% 530 10% After Deductibit Out-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% 530 10% After Deductibit Out-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% 530 10% After Deductibit Out-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20%	Diagnostic X-ray & Laboratory Procedures	0%	20%	20%	10%	30%	\$0	10% After Deductible
Outpatient Hospital 0% 20% 20% 10% 30% S30 10% After Deductible Outpatient Surgery (<i>Performed in Hospital or Surgery Center</i>) 0% 20% 20% 10% 30% 530 10% After Deductible Emergency Room Visit (<i>Weived if Admitted</i>) \$100 \$100 \$100 \$100, then 20% \$100, then 10% \$100, then 30% \$100 10% After Deductible MRTAL HEATH Kass Substance Advances \$100, then 20% \$100, then 10% \$100, then 30% \$100 10% After Deductible MRTAL HEATH Kass Substance Advances 6/10 advances \$20% 20% 10% 30% \$30 10% After Deductible Out-Patient: Facility Based Care (<i>Prior Authorization Required</i>) 0% 20% 20% 10% 30% \$30 10% After Deductible Acupuncture (<i>Limits Apply</i>) 0% 20% 20% 10% 30% \$10/30 visits combined with Chicogradic I.// Authorized Durable Medical Equipment (DME) 0% 20% 20% 10% 30% \$10/30 visits combined with Acupuncture <	HOSPITAL & SKILLED NURSING FACILITY SERVICES							
Outpatient Surgery (Performed in Hospital or Surgery Center) 0% 20% 20% 10% 30% S30 10% After Deductibility Emergency Room Visit (Waived if Admitted) \$100 \$100; then 20% \$100; then 20% \$100; then 10% \$100; then 30% \$100 10% After Deductibility MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT 10% 30% \$0 10% After Deductibility In-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% \$0 10% After Deductibility Out-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% \$10/30 visits combined United Coverage Acupuncture (Limits Apply) 0% 20% 20% 10% 30% \$10/30 visits combined Influtorized Coverage Influtorized Coverage Influtorized Influtorized Coverage Influtorized Coverage Influtorized With Chicopractic	In-Patient Hospital (Prior Authorization Required)	0%	20%	20%	10%	30%	\$0	10% After Deductible
Emergency Room Visit (Waived if Admitted) \$100 \$100; then 20% \$100; then 10% \$100; then 30% \$100 10% After Deductibit MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT In-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% \$00 10% After Deductibit Out-Patient: Facility Based Care (Prior Authorization Required) 0% 20% 20% 10% 30% \$30 10% After Deductibit OTHER SERVICES 0% 20% 20% 10% 30% \$10/30 visits combined with Chiroparatic diff Authorized Limited Coverage with Actipuncture None \$10/30 visits combined with Acquinture Not Covered Durable Medical Equipment (DME) 0% 20% 20% 10% 30% \$10/30 visits combined with Acquinture Not Covered with Acquinture Individual/Family Rund & Specialty Rx Deductibles 0% 20% 20% 10% 30% \$30 10% After Deductible Individual/Family Rund & Specialty Rx Deductibles <t< td=""><td>Outpatient Hospital</td><td>0%</td><td>20%</td><td>20%</td><td>10%</td><td>30%</td><td>\$30</td><td>10% After Deductible</td></t<>	Outpatient Hospital	0%	20%	20%	10%	30%	\$30	10% After Deductible
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENTIn-Patient: Facility Based Care (Prior Authorization Required)0%20%20%10%30%\$010% After DeductibleOut-Patient: Facility Based Care (Prior Authorization Required)0%20%20%10%30%\$3010% After DeductibleOTHER SERVICESAcupuncture (Limits Apply)0%20%20%10%30%\$10/30 visits combinedIlimited CoverageAcupuncture (Limits Apply)0%20%20%10%30%\$10/30 visits combinedIf AuthorizedChiropractic (Limits Apply)0%20%20%10%30%\$10/30 visits combinedInf AuthorizedChiropractic (Limits Apply)0%20%20%10%30%\$10/30 visits combinedNot CoveredDurable Medical Equipment (DME)0%20%20%10%30%\$3010% After DeductiblePhysical and Occupational Therapy (Limits Apply)0%20%20%10%30%\$3010% After DeductibleIndividual/Family Rx Out-of-Pocket (OOP) Max\$2,500/\$3,500\$20/5500Included with Medical Deductible*NoneIncluded with Medical OOP Max*Medical OOP Max*Medi	Outpatient Surgery (Performed in Hospital or Surgery Center)	0%	20%	20%	10%	30%	\$30	10% After Deductible
In-Patient: Facility Based Care (Prior Authorization Required)0%20%20%10%30%\$010% After DeductibieOut-Patient: Facility Based Care (Prior Authorization Required)0%20%20%10%30%\$3010% After DeductibieOther SterVICEAcupuncture (Limits Apply)0%20%20%10%30%\$10/30 visits combined with ChiropracticIllmited Coverage (f Authorized)Anbulance (Ground or Air)5100\$100; then 20%\$100; then 20%\$100; then 10%\$100; then 30%\$5010% After DeductibieChiropractic (Limits Apply)0%20%20%10%30%\$100; then 30%\$10010% After DeductibieDurable Medical Equipment (DME)0%20%20%10%30%\$10/30 visits combined with ChiropracticNot CoveredPHARMACE DETERT0%20%20%10%30%\$010% After DeductibieIndividual/Family Brand & Specialty Rx DeductiblesNone\$200/\$500\$200/\$500Included with Medical Deductible*Included with Medical Deductible*NoneMedical DeductibleIndividual/Family Rx Dut-of-Pocket (OOP) Max\$2,500/\$3,500\$2,500/\$3,500\$2,500/\$3,500Included with Medical DOP Max*NoneIncluded with Medical OOP Max*Medical OOP Max* <td< td=""><td>Emergency Room Visit (Waived if Admitted)</td><td>\$100</td><td>\$100; then 20%</td><td>\$100; then 20%</td><td>\$100; then 10%</td><td>\$100; then 30%</td><td>\$100</td><td>10% After Deductible</td></td<>	Emergency Room Visit (Waived if Admitted)	\$100	\$100; then 20%	\$100; then 20%	\$100; then 10%	\$100; then 30%	\$100	10% After Deductible
Out-Patient: Facility Based Care (Prior Authorization Required)0%20%20%10%30%\$3010% After DeductibleOTHER SERVICESAcupuncture (limits Apply)0%20%20%10%30%\$10/30 visits combined with ChiropracticLimited Coverage If AuthorizedAmbulance (Ground or Air)51005100; then 20%5100; then 20%5100; then 10%\$100; then 30%\$10/30 visits combined with AcupunctureChiropractic (Limits Apply)0%20%20%10%30%\$10/30 visits combined with AcupunctureDurable Medical Equipment (DME)0%20%20%10%30%\$3010% After DeductiblePhysical and Occupational Therapy (Limits Apply)0%20%20%10%30%\$3010% After DeductiblePHARMACY BENEFTSIndividual/Family Brand & Specialty Rx DeductiblesNone\$200/\$500\$200/\$500Included with Medical Deductible*NoneIncluded with Medical Deductible*Included with Medical Deductible*Included with Medical Deductible*Included with Medical DOM Max*Included with Medical DOM Max*Included with Medical DOP MaxIncluded with Medical DOP MaxIncluded with 	MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT							
OTHER SERVICES Acupuncture (<i>Limits Apply</i>) 0% 20% 20% 10% 30% \$10/30 visits combined with Chiropractic Limited Coverage If Authorized Ambulance (<i>Ground or Air</i>) \$100 \$100, then 20% \$100, then 20% \$100, then 10% \$100, then 30% \$50 10% After Deductible Chiropractic (<i>Limits Apply</i>) 0% 20% 20% 10% 30% \$10/30 visits combined with Acupuncture Not Covered Durable Medical Equipment (DME) 0% 20% 20% 10% 30% \$0 10% After Deductible PHARMACY BENEFTS 0% 20% 20% 10% 30% \$30 10% After Deductible Individual/Family Rx Out-of-Pocket (OOP) Max \$2,500/\$3,500 \$2,500/\$53,500 \$2,500/\$3,500 \$1,500/\$3,500 Included with Medical Deductible * Medical OOP Max *	In-Patient: Facility Based Care (Prior Authorization Required)	0%	20%	20%	10%	30%	\$0	10% After Deductible
Acupuncture (Limits Apply)0%20%20%10%30%\$10/30 visits combined with ChiropracticLimited Coverage if AuthorizedAmbulance (Ground or Air)\$100\$100\$100; then 20%\$100; then 20%\$100; then 10%\$100; then 30%\$5010% After DeductibleChiropractic (Limits Apply)0%20%20%10%30%\$10/30 visits combined with AcupunctureNot CoveredDurable Medical Equipment (DME)0%20%20%10%30%\$010% After DeductiblePhysical and Ocupational Therapy (Limits Apply)0%20%20%10%30%\$010% After DeductiblePharMACY BENEFTSIndividual/Family Brand & Specialty Rx DeductiblesNone\$200/\$500\$200/\$500Included with Medical Deductible*NoneIncluded with Medical OOP Max *Included with Medical OOP Max *Included with Medical OOP Max *Included with Medical OOP Max *None\$10.0 ther Network\$10.0 ther Network\$10.0 ther Network\$35 after Deductible\$35 after Deductible\$30.0 dy supply\$10Brand - 30 days supply\$35 Navitus Mail ONLY\$35 Navitus Mail ONLY	Out-Patient: Facility Based Care (Prior Authorization Required)	0%	20%	20%	10%	30%	\$30	10% After Deductible
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Chiropractic (Limits Apply)0%20%20%10%30%with AcupunctureNot CoveredDurable Medical Equipment (DME)0%20%20%10%30%\$010% After DeductiblePhysical and Occupational Therapy (Limits Apply)0%20%20%10%30%\$30\$3010% After DeductiblePHARMACY BENEFITSIndividual/Family Brand & Specialty Rx DeductiblesNone\$200/\$500\$200/\$500Included with Medical Deductible*NoneIncluded with Medical DeductibleIndividual/Family Rx Out-of-Pocket (OOP) Max\$2,500/\$3,500\$2,500/\$3,500\$2,500/\$3,500Included with Medical OOP Max*Included with Medical OOP Max*Included with Medical OOP Max*Included with Medical OOP MaxIncluded with Medical OOP Max *Included with Medical OOP Max *<	Ambulance (Ground or Air)	\$100	\$100; then 20%	\$100; then 20%	\$100; then 10%	\$100; then 30%	\$50	10% After Deductible
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Specialty - 30 days supply \$35 Navitus Mail ONLY \$35 Navitus Mail ONLY \$35 Navitus Mail ONLY after Deductible after Deductible	Brand - 30 days supply	\$35	\$35	\$35	\$35 after Deductible	\$35 after Deductible	\$30-100 day supply	\$30
Mail Order (Generic & Brand - 90 days supply) Free-\$90 Free-\$90 Free-\$90 Free-\$90 Free-\$90 \$10-\$30/100 day supply \$20-\$60/100 day supply	Specialty - 30 days supply	\$35 Navitus Mail ONLY	\$35 Navitus Mail ONLY	\$35 Navitus Mail ONLY			\$30-30 day supply	\$30
	Mail Order (Generic & Brand - 90 days supply)	Free-\$90	Free-\$90	Free-\$90	Free-\$90	Free-\$90	\$10-\$30/100 day supply	\$20-\$60/100 day supply

* Primary Care Providers are: Family or General Practitioner, Internist, Gynecologist, Obstetrician, Pediatrician or Nurse Practitioner



Ripon Unified School District

This is a limited summary of Dental Plan Benefits for Plan Year October 2023. For detailed coverage refer to the Plan Document. All benefits shown assume In-Network coverage only.

	Delta Dental Plan Premier Plan	Delta Dental Plan Preferred Plan
COMPOSITE Premium Rate	\$93	\$85
CALENDAR YEAR Deductibles & Maximums	MEMBER PAYS	MEMBER PAYS
Individual/Family Deductibles	\$0/\$0	\$0/\$0
Individual/Family Maximum	\$1,500	\$1,500
Covered Service	PLAN PAYS	PLAN PAYS
Diagnostic & Preventive Services Exams, X-rays, 2 Cleanings Per Calendar Year	70-100%	100%
Basic Services Fillings, Simple Tooth Extractions, Sealants	70-100%	100%
Endodontics Root Canals Covered Under Basic Services	70-100%	100%
Oral Surgery Covered Under Basic Services	70-100%	100%
Major Services Crowns, Inlays, Onlays & Cast Restorations	70-100%	100%
Prosthodontics Bridges, Dentures & Implants	50%	50%
Orthodontics Adult & Dependent Children	Not Covered	Not Covered
Dental Accident Benefits	100% Additional \$1,000 Benefits	100% Additional \$1,000 Benefits



Ripon Unified School District

This is a limited summary of Vision Plan Benefits for Plan Year October 2023. For detailed coverage refer to the Plan Document

	Signature VSP Plan - C-\$10
COMPOSITE Premium Rate	\$23.60
CALENDAR YEAR Deductibles & Maximums	MEMBER PAYS
Individual Copayments	\$10
FREQUENCY OF SERVICE	PLAN PAYS
Comprehensive Vision Exam	Once Every Calendar Year
Lenses	One Pair Every Calendar Year
Frames	One Pair Every Calendar Year
Contact Lenses - Non-Elective	One Pair Every Calendar Year
Contact Lenses - Elective	One Pair Every Calendar Year
BENEFIT ALLOWANCE	PLAN PAYS
Comprehensive Examination	100% - Participating Provider
Single Vision Lenses	100% - Participating Provider
Bifocal Lenses	100% - Participating Provider
Trifocal Lenses	100% - Participating Provider
Progressive Lenses	Up to \$89.50 - Participating Provider
Aphakic Monofocal	100% - Participating Provider
Aphakic Multifocal	100% - Participating Provider
Frames	Up to \$150 - Participating Provider
Contact Lenses - Non-Elective	100% - Participating Provider
Contact Lenses - Elective	Up to \$150 - Participating Provider



Take advantage of no cost benefits to help you get and stay healthy

BENEFIT HIGHLIGHTS

AVAILABILITY AND HOW TO GET STARTED

24/7 Help with Personal Concerns <i>SISC Employee Assistance Program</i> Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	All employees at member districts Call 800-999-7222 Visit anthemEAP.com and enter SISC	inge Kont inger Skri
24/7 Virtual Primary Care Doctor <i>Eden Health</i> Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.	Anthem and Blue Shield PPO members Scan the QR code to download the Eden Health app, and register for your Eden Health membership.	•
Personal Health Coaching Vida Health Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	Anthem and Blue Shield members Call 855-442-5885 Visit vida.com/sisc	
24/7 Physician Access—Anytime, Anywhere <i>MDLive</i> Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.	Anthem and Blue Shield members Call 888-632-2738 Visit mdlive.com/sisc	
Free Generic Medications Costco Access most generic medications at no cost through Costco retail and mail oder pharmacies. You don't need to be a Costco member.	Anthem and Blue Shield members Call 800-774-2678 (press 1) Visit costco.com	



AVAILABILITY AND HOW TO GET STARTED

Physical Therapy for Back or Joint Pain Hinge Health	Anthem and Blue Shield PPO members	
Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	Call 855-902-2777 Visit hingehealth.com/sisc	
24/7 Access to Virtual Maternity and Postpartum Support Maven Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists coaches and other maternity providers to help deal with pregnancy and postpartum concerns.	Anthem and Blue Shield PPO members Call 855-442-5885 Visit mavenclinic.com/join/SISC	
Hip, Knee, and Spine Surgical Benefit <i>Carrum Health</i> Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	Anthem and Blue Shield PPO members Call 888-855-7806 Visit carrumhealth.com/sisc	
Enhanced Cancer Benefit <i>Contigo Health</i> Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.	Anthem and Blue Shield PPO members Call 877-220-3556 Visit sisc.contigohealth.com	

Per IRS guidelines, SISC HSA Members may not be eligible for these programs.

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