SISC
Self-Insured Schools of California
*Schools Helping Schools*

## Santa Cruz City Schools - Certificated - SISC Medical Plan Comparison - Effective October 1, 2020

| SISC PLAN NAME | Blue Shield HMO-Full (includes PAMF) 30-20%, Rx 9-35 Payroll ID: HMOBSH | Blue Shield TRIO HMO 30-20%, Rx 9-35 Payroll ID: HMOPMG | Blue Shield HMO-Full (includes PAMF) 40-40%, Rx $200/10-35 Payroll ID: HMOBSL | Kaiser HMO $30-0, Rx 10-30 Payroll ID: HMOK | Blue Shield PPO** 80-M $40, Rx 9-35 Payroll ID: PPOBSH | Blue Shield PPO** HDHP - HSA- Plan B Payroll ID: PPOBSL | Blue Shield PPO** Minimum Value Plan Payroll ID: PPOBSMV | Blue Shield PPO ** WABE (Single Only) Payroll ID: WABEB |
|---|---|---|---|---|---|---|---|---|
| **GROUP NUMBER** | **1H011000** $30-20% | **1H111000** $30-20% | **H051000** $40-40% | **605337-0004** $30-0 | **0P011000** 80-M $40 | **0P021000** HSA-Plan B | **0P041003** MINIMUM VALUE (Dental & Vision Included) | **WABE69815B** ANCHOR BRONZE (Dental & Vision Included) |
| | **Member Pays** | **Member Pays** | **Member Pays** | **Member Pays** | **Member Pays** | **Member Pays** | **Member Pays** | **Member Pays** |
| Individual/Family Deductibles | **$0/$0** | **$0/$0** | **$0/$0** | **$0/$0** | **$3,000/$6,000** | **$3,000/$5,200** | **$5,000/$10,000** | **$5,000/$10,000** |
| Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance) | **$1,500/$3,000** | **$1,500/$3,000** | **$3,500/$7,000** | **$1,500/$3,000** | **$4,000/$8,000** | **$5,000/$10,000** | **$6,350/$12,700** | **$6,350/$12,700** |
| ***PROFESSIONAL SERVICES*** | | | | | | | | |
| Office Visit co-pay | **$30** | **$30** | **$40** | **$30** | **$40** | 10% | 30% After deductible is met | 30% After deductible is met |
| Urgent Care co-pay | **$30** | **$30** | **$40** | **$30** | **$40** | 10% | 30% After deductible is met | 30% After deductible is met |
| Specialists/Consultants co-pay | **$45** | **$45** | **$50** | **$30** | **$40** | 10% | 30% After deductible is met | 30% After deductible is met |
| Prenatal, postnatal office visit co-pay | **$30** | **$30** | **$0** | **$0** | **$40** | 10% | 30% After deductible is met | 30% After deductible is met |
| Scans: CT, CAT, MRI, PET etc. | $0 | $0 | $0 | $0 | 20% | 10% | 30% | 30% |
| Diagnostic X-ray & Laboratory Procedures | $0 | $0 | $0 | $0 | 20% | 10% | 30% | 30% |
| Infertility (diagnosis/treatment of causes of infertility) | 50% | 50% | 50% | Office visit co-pay or hospitalization co-pay applies | Not covered | Not covered | Not covered | Not covered |
| Preventive Care Services (includes physical exams & screenings) | $0 | $0 | $0 | $0 | 0%, Deductible Waived | 0%, Ded Waived | 0%, Ded Waived | 0%, Ded Waived |
| ***HOSPITAL & SKILLED NURSING FACILITY SERVICES*** | | | | | | | | |
| Emergency Room visit co-pay (waived if admitted) | $150 | $150 | $200 | $100 | $100 co-pay + 20% | 10% $100 co-pay | 30% $100 co-pay | 30% $100 co-pay |
| Inpatient Hospital co-pay (preauthorization required) | 20% | 20% | 40% | $0 | 20% | 10% | 30% | 30% |
| Outpatient Hospital co-pay | $0 | $0 | $40 | $30 | 20% | 10% | 30% | 30% |
| Surgery, Outpatient (performed in an Ambulatory Surgery Center) | $0 | $0 | 40% | $30 | 20% | 10% | 30% | 30% |
| Surgery, Outpatient (performed in a Hospital) | $0 | $0 | $0 | $30 | 20% | 10% | 30% | 30% |
| ***MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT*** | | | | | | | | |
| **INPATIENT CARE:** Facility based care (preauthorization required) | 20% | 20% | 40% | $0 | 20% | 10% | 30% | 30% |
| **OUTPATIENT CARE:** Facility based care (preauthorization required) | $30 | $30 | $40 | $30 | $40 | 10% | 30% | 30% |
| ***OTHER SERVICES*** | | | | | | | | |
| Acupuncture - Limits apply | $10/30 visits combined w/chiro Use ASH network | $10/30 visits combined w/chiro Use ASH network | $10/30 visits combined w/chiro Use ASH network | $10/30 visits | 20% | 10% | 30% | 30% |
| Ambulance (Ground or Air) | $100 | $100 | $100 | $50 | $100 co-pay + 20% | $100 co-pay + 10% | 30% after $100 co-pay | 30% after $100 co-pay |
| Chiropractic - Limits apply | $10/30 visits combined w/acu Use ASH Network | $10/30 visits combined w/acu Use ASH Network | $10/30 visits combined w/acu Use ASH Network | $10/30 visits | 20% | 10% | 30% | 30% |
| Durable Medical Equipment (DME) | 20% | 20% | 40% | $0 | 20% | 10% | 30% | 30% |
| Physical and Occupational Therapy - Limits apply | $30 | $30 | $40 | $30 | 20% | 10% | 30% | 30% |
| ***PRESCRIPTION DRUG PLANS*** | | | | | | | | |
| Provider Network | **Navitus** | **Navitus** | **Navitus** | **Kaiser** | **Navitus** | **Blue Shield** | **Blue Shield** | **Blue Shield** |
| Generic co-pay/days supply | $9 / 30-day | $9 / 30-day | $10 / 30-day | $10 /100-day | $9 / 30-day | After Medical deductible, $9/ 30-day | After Medical deductible, $9/ 30-day | After Medical deductible, $9/ 30-day |
| Brand co-pay/days supply | $35 / 30-day | $35 / 30-day | $35 / 30-day | $30 /100-day | $35 / 30-day | After medical deductible, $35/30-day | After medical deductible, $35/30-day | After medical deductible, $35/30-day |
| Prescription Deductible Brand Drugs Only (ind/family) | No Rx Deductible | No Rx Deductible | $200 / $500 | No Rx Deductible | No Rx Deductible | Medical Ded. Applies | Medical Ded. Applies | Medical Ded. Applies |
| Mail Order (Generic-Brand co-pay/days supply) | $0 - $90 / 90-day | $0 - $90 / 90-day | $0 - $90 / 90-day | $10-30 /100-day | $0 - $90 / 90-day | After medical deductible, $0-90/90-day | After medical deductible, $18-90/90-day | After medical deductible, $18-90/90-day |
| Prescription Drug Out-of-Pocket Maximum | $2,500 / $3,500 | $2,500 / $3,500 | $2,500 / $3,500 | $2,500 / $3,500 | $2,500 / $3,500 | Medical OOP Maximum applies | Medical OOP Maximum applies | Medical OOP Maximum applies |

**Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet. **For PPO plans, deductibles must be met before certain services are covered see Summary of Benefits for more information. Plans with a deductible all have 4th quarter deductible carryover (October 1-December 31) except for the HDHP-HSA plan. Co-pays and co-insurance do not carryover to the next calendar year. To find a participating or contracting provider call the customer service number on your ID card or visit www.blueshieldca.com Pharmacy benefits have separate OOP Maximums when covered through Navitus.**