SISC
Self-Insured Schools of California
Schools Helping Schools

Santa Cruz City Schools - Classified & Confidential - SISC Medical Plan Comparison Effective October 1, 2019

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) $25-500, Rx 5-20 PLAN ID: HMOBSH	Blue Shield TRIO HMO $25-500, Rx 5-20 PLAN ID: HMOPMG	Kaiser HMO $0 CO PAY, Rx 5-5 PLAN ID: HMOK	Blue Shield PPO 90-E $20, Rx 7-25 PLAN ID: PPOBSH	Blue Shield PPO 80-K $30, Rx 5-20 PLAN ID: PPOBSL
GROUP NUMBER	**1H031001**	**1H081001**	**605337**	**0P031001**	**0P051001**
	Member Pays	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	**$0/$0**	**$0/$0**	**$0/$0**	**$300/$600**	**$1,000/$2,000**
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	**$2,000/$4,000**	**$2,000/$4,000**	**$1,500/$3,000**	**$1,000/$3,000**	**$3,000/$6,000**
PROFESSIONAL SERVICES					
Office Visit co-pay	**$25**	**$25**	**$0**	**$20**	**$30**
Urgent Care co-pay	**$25**	**$25**	**$0**	**$20**	**$30**
Specialists/Consultants co-pay	**$25**	**$25**	**$0**	**$20**	**$30**
Prenatal, postnatal office visit co-pay	**$0**	**$0**	**$0**	**$20**	**$30**
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	10%	20%
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	10%	20%
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0	0%, Deductible Waived	0%, Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit co-pay (waived if admitted)	$100	$100	$100	$100 co-pay +10%	$100 co-pay +20%
Inpatient Hospital co-pay (preauthorization required)	$500	$500	$0	10%	20%
Outpatient Hospital co-pay	$500	$500	$0	10%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$150	$150	N/A	10%	20%
Surgery, Outpatient (performed in a Hospital)	$300	$300	$0	10%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					20%
INPATIENT CARE: Facility based care (preauthorization required)	$500	$500	$0	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	$25	$25	$0	Deductible waived; OV co-pay applies	Deductible waived; OV co-pay applies
OTHER SERVICES					20%
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%	20%
Ambulance (Ground or Air)	$100	$100	$50	10%	$100 co-pay + 20%
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%	20%
Durable Medical Equipment (DME)	20%	20%	$0	10%	20%
Physical and Occupational Therapy - Limits apply	$25	$25	$0	10%	20%
PRESCRIPTION DRUG PLANS					
Provider Network	**Navitus**	**Navitus**	**Kaiser**	**Navitus**	**Navitus**
Generic co-pay/days supply	$5 / 30-day	$5 / 30-day	$5 / 30-day	$7 / 30-day	$5 / 30-day
Brand co-pay/days supply	$20 / 30-day	$20 / 30-day	$5 / 30-day	$25 / 30-day	$20 / 30-day
Prescription Deductible Brand Drugs Only (ind/family)	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible
Mail Order (Generic-Brand co-pay/days supply)	$0 - $90 / 90-day	$0 - $90 / 90-day	$0 - $5 / 100-day	$0 - $60 / 90-day	$0 - $90 / 90-day
Prescription Drug Out-of-Pocket Maximum	$1,500 / $2,500	$1,500 / $2,500	$2,500 / $3,500	$1,500 / $2,500	$1,500 / $2,500

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. 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.