



Santa Cruz City Schools - **Certificated** - SISC Medical Plan Comparison - Effective October 1, 2019

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.