SISC Benefit Plan Options

PPO PLANS

	PPO 100%	PPO 90%	PPO 80%
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	See PPO Options page		
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	See PPO Options page		
Professional Services			
Office Visit/Urgent Care Co-pay	See PPO Options page		
Specialists/Consultants Co-pay	See PPO Options page		
Prenatal, Postnatal Office Visit Co-pay	See PPO Options page		
Scans: CT, CAT, MRI, PET, etc.	0%	10%	20%
Diagnostic X-ray and Laboratory Procedures	0%	10%	20%
Infertility Services (see benefit booklet for details)	Not covered		
Preventive Care Services (includes physical exams and screenings)	0%, Deductible Waived		
Hospital and Skilled Nursing Facility Services			
Emergency Room Visit (co-pay waived if admitted)	$100 co-pay	$100 co-pay + 10%	$100 co-pay + 20%
Inpatient Hospital Co-pay (preauthorization required)	0%	10%	20%
Outpatient Hospital Co-pay	0%	10%	20%
Surgery, Outpatient (performed in an ambulatory surgery center)	0%	10%	20%
Surgery, Outpatient (performed in a hospital)	0%	10%	20%
Mental Health Services and Substance Abuse Treatment			
Inpatient Care—Facility-based care (preauthorization required)	0%	10%	20%
Outpatient Care—Facility-based care (preauthorization required)	Deductible waived; office visit co-pay applies		
Other Services			
Acupuncture—Limits apply	0%	10%	20%
Ambulance (ground or air)	$100 co-pay	$100 co-pay + 10%	$100 co-pay + 20%
Chiropractic—Limits apply	0%	10%	20%
Durable Medical Equipment (DME)	0%	10%	20%
Hearing Aids ($700 benefit allowance per 24-month period)	Cost in excess of allowance		
Physical and Occupational Therapy—Limits apply	0%	10%	20%
Prescription Drug Plans			
Generic Co-pay/Days Supply	See Prescription Drug Plan Chart		
Brand Co-pay/Days Supply	See Prescription Drug Plan Chart		
Mail Order (generic-brand co-pay/days supply)	See Prescription Drug Plan Chart		

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PPO PLAN OPTIONS

Calendar Year Deductibles, Out-of-Pocket (OOP) Maximums and Co-pays

100% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
100-A $10	$0/$0	$1,000/$3,000	$10
100-A $20	$0/$0	$1,000/$3,000	$20
100-B $20	$100/$300	$1,000/$3,000	$20
100-C $20	$200/$400	$1,000/$3,000	$20
100-D $20	$300/$600	$1,000/$3,000	$20
100-G $20	$500/$1,000	$1,000/$3,000	$20

90% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
90-A $20	$100/$300	$1,000/$3,000	$20
90-C $20	$200/$500	$1,000/$3,000	$20
90-G $20	$500/$1,000	$1,000/$3,000	$20

80% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
80-C $20	$200/$500	$1,000/$3,000	$20
80-E $20	$300/$600	$1,000/$3,000	$20
80-G $20	$500/$1,000	$2,000/$4,000	$20
80-G $30	$500/$1,000	$2,000/$4,000	$30
80-J $30	$750/$1,500	$3,000/$6,000	$30
80-K $30	$1,000/$2,000	$3,000/$6,000	$30
80-L $30	$2,000/$4,000	$4,000/$8,000	$30
80-M $40	$3,000/$6,000	$4,000/$8,000	$40

Calendar-year Out-of-Pocket Maximums include plan co-pays, deductible and co-insurance for in-network and emergency services.

Medical Out-of-Pocket Maximums shown are for medical plans only. See Prescription Drug Page for applicable Pharmacy Out-of-Pocket Maximums.

Plans shown on this page are non-HSA compliant.

PRESCRIPTION DRUG PLANS 2021-2022

Free Generic Drugs at Costco as well as through Mail Order (80% of prescriptions are filled with Generic Drugs)

Costco Pharmacies are open to non-Costco members.

		WALK-IN			MAIL	
	DAYS SUPPLY	NETWORK 30	COSTCO 30	COSTCO 90	COSTCO 90	NAVITUS 30
Plan 5-20	Generic	$5	**FREE**	**FREE**	**FREE**	N/A
	Brand	$20	$20	$50	$50	N/A
	Specialty*	N/A	N/A	N/A	N/A	$20
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family			$1,500 Individual/$2,500 Family	N/A
Plan 7-25	Generic	$7	**FREE**	**FREE**	**FREE**	N/A
	Brand	$25	$25	$60	$60	N/A
	Specialty*	N/A	N/A	N/A	N/A	$25
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family			$1,500 Individual/$2,500 Family	N/A
Plan 9-35	Generic	$9	**FREE**	**FREE**	**FREE**	N/A
	Brand	$35	$35	$90	$90	N/A
	Specialty*	N/A	N/A	N/A	N/A	$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A
Plan 200 10-35	Brand/Specialty Deductible**	$200 Individual/$500 Family			$200 Individual/$500 Family	N/A
	Generic	$10	**FREE**	**FREE**	**FREE**	N/A
	Brand	$35	$35	$90	$90	N/A
	Specialty*	N/A	N/A	N/A	N/A	$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A
Plan 200 15-50	Brand/Specialty Deductible**	$200 Individual/$500 Family			$200 Individual/$500 Family	N/A
	Generic	$15	**$5**	**$15**	**$15**	N/A
	Brand	$50	$50	$135	$135	N/A
	Specialty*	N/A	N/A	N/A	N/A	$50
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A

** Drugs designated as Specialty Drugs are only available in 30-day supplies through the mail from Navitus.*
*** Rx plans on this page with a deductible include fourth quarter carryover. Once the deductible has been satisfied, the member will be responsible for the brand name co-pay.*

Free Generic Drugs at Costco as well as through Mail Order

- **The $200/$15-$50 Rx Plan features reduced generic copays at Costco (not free).**
- **Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.**
- **Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.**

Generic Co-Pays for Lancets and Syringes

Generic Co-Pays for Test Strips manufactured by Abbott (Freestyle) and Lifescan (One Touch)

- **Diabetic supplies are only available as brand prescriptions and not generic. However, the SISC pharmacy plans charge the generic co-pay for Lancets and Syringes. In addition, SISC pharmacy plans charge the generic co-pay on Test Strips manufactured by Abbott (Freestyle) and Lifescan (One touch). The brand co-pay is charged for all test strips from other manufacturers.**

The group plan benefits must be communicated without modification to the members. A district may not partially pay, reimburse or otherwise reduce the member's responsibility for deductibles, co-pays, coinsurance, etc.

KAISER HMO PLANS

	Kaiser Traditional HMO $10/$10	Kaiser Traditional HMO $20/$10-$20	Kaiser Traditional HMO $30/$10-$30	Kaiser Deductible HMO $500 Hospital ONLY	Kaiser Deductible HMO $1,000 Hospital ONLY
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0	$0	$0	$500/$1,000	$1,000/$2,000
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000
Professional Services					
Office Visit/Urgent Care Co-pay	$10	$20	$30	$20	$20
Specialists/Consultants Co-pay	$10	$20	$30	$20	$20
Prenatal, Postnatal Office Visit Co-pay			$0		
Scans: CT, CAT, MRI, PET, etc.	$0	$0	$0	10% up to $50	10% up to $50
Diagnostic X-ray and Laboratory Procedures	$0	$0	$0	$10	$10
Infertility (see benefit booklet for details)		Office visit co-pay or hospitalization co-pay applies			
Preventive Care Services (includes physical exams and screenings)	$0	$0	$0	$0, ded waived	$0, ded waived
Hospital and Skilled Nursing Facility Services					
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	10% (after ded)	20% (after ded)
Inpatient Hospital Co-pay (preauthorization required)	$0	$0	$0	10% (after ded)	20% (after ded)
Outpatient Hospital Co-pay	$10	$20	$30	10% (after ded)	20% (after ded)
Surgery, Outpatient (performed in an ambulatory surgery center)	$10	$20	$30	10% (after ded)	20% (after ded)
Surgery, Outpatient (performed in a hospital)	$10	$20	$30	10% (after ded)	20% (after ded)
Mental Health Services and Substance Abuse Treatment					
Inpatient Care—Facility-based care (preauthorization required)	$0	$0	$0	10% (after ded)	20% (after ded)
Outpatient Care—Facility-based care (preauthorization required)	$10	$20	$30	10% (after ded)	20% (after ded)
Other Services					
Acupuncture—Limits apply			$10/30 visits		
Ambulance (ground or air)	$50	$50	$50	$150	$150
Chiropractic—Limits apply			$10/30 visits		
Durable Medical Equipment (DME)	$0	$0	$0	20% (after ded)	20% (after ded)

	Kaiser Traditional HMO $10/$10	Kaiser Traditional HMO $20/$10-$20	Kaiser Traditional HMO $30/$10-$30	Kaiser Deductible HMO $500 Hospital ONLY	Kaiser Deductible HMO $1,000 Hospital ONLY
Hearing Aids ($500 benefit allowance/device—1 device/ear—2 devices/36-month period)		Cost in excess of allowance			
Physical and Occupational Therapy—Limits apply	$10	$20	$30	$20	$20
Prescription Drug Plans					
Generic Co-pay/Days Supply	$10/100-day	$10/100-day	$10/100-day	$10/30-day	$10/30-day
Brand Co-pay/Days Supply	$10/100-day	$20/100-day	$30/100-day	$30/30-day	$30/30-day
Mail Order (generic-brand co-pay/days supply)	$10/100-day	$10-20/ 100-day	$10-30/ 100-day	$20-60/ 100-day	$20-60/ 100-day

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KAISER HSA PLANS

	HSA-A Kaiser—Single Coverage	HSA-A Kaiser—Family Coverage	HSA-B Kaiser
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$1,500/$3,000	$2,800/$3,000	$3,000/$5,950
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$3,000/$6,000	$3,000/$6,000	$6,000/$11,900
Professional Services			
Office Visit/Urgent Care Co-pay	10%		20%
Specialists/Consultants Co-pay	10%		20%
Prenatal, Postnatal Office Visit Co-pay	$0		$0
Scans: CT, CAT, MRI, PET, etc.	10%		20%
Diagnostic X-ray and Laboratory Procedures	10%		20%
Infertility (see benefit booklet for details)	Office visit co-pay or hospitalization co-pay applies		Office visit co-pay or hospitalization co-pay applies
Preventive Care Services (includes physical exams and screenings)	0%, ded waived		0%, ded waived
Hospital and Skilled Nursing Facility Services			
Emergency Room Visit (co-pay waived if admitted)	10%		20%
Inpatient Hospital Co-pay (preauthorization required)	10%		20%
Outpatient Hospital Co-pay	10%		20%
Surgery, Outpatient (performed in an ambulatory surgery center)	10%		20%
Surgery, Outpatient (performed in a hospital)	10%		20%
Mental Health Services and Substance Abuse Treatment			
Inpatient Care—Facility-based care (preauthorization required)	10% after deductible		20% (after ded)
Outpatient Care—Facility-based care (preauthorization required)	10% after deductible		20% (after ded)
Other Services			
Acupuncture—Limits apply	Limited coverage, if authorized		Limited coverage, if authorized
Ambulance (ground or air)	10%		20%
Chiropractic—Limits apply	Not covered		Not covered
Durable Medical Equipment (DME)	10%		20%
Hearing Aids	Not covered		Not covered
Physical and Occupational Therapy—Limits apply	10%		20%
Prescription Drug Plans			
Generic Co-pay/Days Supply	$10/30-day (after ded)		$10/30-day (after ded)
Brand Co-pay/Days Supply	$30/30-day (after ded)		$30/30-day (after ded)
Mail Order (generic-brand co-pay/day supply)	$20–60/100-day (after ded)		$20–60/100-day (after ded)

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ANTHEM BLUE CROSS HMO PLANS

	Anthem Premier HMO 10	Anthem Premier HMO 20	Anthem Classic HMO 20/40/250 Admit	Anthem Value HMO 30/40/500/ 3 day
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0			
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Professional Services				
Office Visit/Urgent Care Co-pay	$10	$20	$20	$30
Specialists/Consultants Co-pay	$10	$20	$40	$40
Prenatal, Postnatal Office Visit Co-pay	$10	$20	$20	$30
Scans: CT, CAT, MRI, PET, etc.	$100 per test			
Diagnostic X-ray and Laboratory Procedures	$0			
Infertility (see benefit booklet for details)	50%			
Preventive Care Services (includes physical exams and screenings)	$0			
Hospital and Skilled Nursing Facility Services				
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	$150
Inpatient Hospital Co-pay (preauthorization required)	$0	$200	$250	$500/day 3-day max
Outpatient Hospital Co-pay	$0	$100	$125	$250
Surgery, Outpatient (performed in an ambulatory surgery center)	$0	$100	$125	$250
Surgery, Outpatient (performed in a hospital)	$0	$100	$125	$250
Mental Health Services and Substance Abuse Treatment				
Inpatient Care Facility-based care (preauthorization required)	$0	$200	$250	$500/day 3-day max
Outpatient Care Facility-based care (preauthorization required)	$0			
Other Services				
Acupuncture • Via HMO Plan—PCP-referred (limits apply) • Via Plan Rider—Self-referred (limits apply)	• Office visit co-pay • $10/30 visits combined with chiropractic			
Ambulance (ground or air)	$100			
Chiropractic • Via HMO Plan—PCP-referred (limits apply) • Via Plan Rider—Self-referred (limits apply)	• Office visit co-pay • $10/30 visits combined with acupuncture			
Durable Medical Equipment (DME)	0%	20%	20%	50%
Hearing Aids (50% benefit allowance/1 device/36 months)	Cost in excess of allowance			
Physical and Occupational Therapy—Limits apply	$10	$20	$40	$40

	Anthem Premier HMO 10	Anthem Premier HMO 20	Anthem Classic HMO 20/40/250 Admit	Anthem Value HMO 30/40/500/ 3 day
Prescription Drug Plans				
Generic Co-pay/Days Supply	See Prescription Drug Plan Chart			
Brand Co-pay/Days Supply	See Prescription Drug Plan Chart			
Mail Order (generic-brand co-pay/days supply)	See Prescription Drug Plan Chart			

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BLUE SHIELD HMO PLANS

	Blue Shield HMO 10-0	Blue Shield HMO 20-250	Blue Shield HMO 25-500	Blue Shield HMO 30-20% Zero Facility
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0			
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$1,500/$3,000
Professional Services				
Office Visit/Urgent Care Co-pay	$10	$20	$25	$30
Specialists/Consultants Co-pay	$10	$20	$25	$30
Prenatal, Postnatal Office Visit Co-pay	$0	$0	$0	$30
Scans: CT, CAT, MRI, PET etc.	$0			
Diagnostic X-ray and Laboratory Procedures	$0			
Infertility (see benefit booklet for details)	50%			
Preventive Care Services (includes physical exams and screenings)	$0			
Hospital and Skilled Nursing Facility Services				
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	$150
Inpatient Hospital Co-pay (preauthorization required)	$0	$250	$500	20%
Outpatient Hospital Co-pay	$0	$250	$500	$0
Surgery, Outpatient (performed in an ambulatory surgery center)	$0	$100	$150	$0
Surgery, Outpatient (performed in a hospital)	$0	$150	$300	$0
Mental Health Services and Substance Abuse Treatment				
Inpatient Care Facility-based care (preauthorization required)	$0	$250	$500	20%
Outpatient Care Facility-based care (preauthorization required)	$10	$20	$25	$30
Other Services				
Acupuncture—Limits apply	$10/30 visits combined with chiropractic			
Ambulance (ground or air)	$100			
Chiropractic—Limits apply	$10/30 visits combined with acupuncture			
Durable Medical Equipment (DME)	0%	20%	20%	20%
Hearing Aids (50% benefit allowance/1 device/24 months)	Cost in excess of allowance			
Physical and Occupational Therapy—Limits apply	$10	$20	$25	$30
Prescription Drug Plans				
Generic Co-pay/Days Supply	See Prescription Drug Plan Chart			
Brand Co-pay/Days Supply	See Prescription Drug Plan Chart			
Mail Order (generic-brand co-pay/days supply)	See Prescription Drug Plan Chart			

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MINIMUM VALUE—ANCHOR BRONZE PLANS

	Minimum Value	Anchor Bronze
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	
Individual/Family Deductibles	$5,000/$10,000	
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$6,350/$12,700	
Professional Services		
Office Visit/Urgent Care Co-pay	30% after deductible	
Specialists/Consultants Co-pay	30% after deductible	
Prenatal, Postnatal Office Visit Co-Pay	30% after deductible	
Scans: CT, CAT, MRI, PET, etc.	30%	
Diagnostic X-ray and Laboratory Procedures	30%	
Infertility (see benefit booklet for details)	Not covered	
Preventive Care Services (includes physical exams and screenings)	0%, deductible waived	
Hospital and Skilled Nursing Facility Services		
Emergency Room Visit Co-pay (waived if admitted)	30% after $100 co-pay	
Inpatient Hospital Co-pay (preauthorization required)	30%	
Outpatient Hospital Co-pay	30%	
Surgery, Outpatient (performed in an ambulatory surgery center)	30%	
Surgery, Outpatient (performed in a hospital)	30%	
Mental Health Services and Substance Abuse Treatment		
Inpatient Care Facility-based care (preauthorization required)	30%	
Outpatient Care Facility-based care (preauthorization required)	30%	
Other Services		
Acupuncture—Limits apply	30%	
Ambulance (ground or air)	30% after $100 co-pay	
Chiropractic—Limits apply	30%	
Durable Medical Equipment (DME)	30%	
Hearing Aids ($700 benefit allowance per 24-month period)	30% plus any cost in excess of allowance	
Physical and Occupational Therapy—Limits apply	30%	
Prescription Drug Plans		
Generic Co-pay/Days Supply	After deductible, $9/30-day	
Brand Co-pay/Days Supply	After deductible, $35/30-day	
Mail Order (generic-brand co-pay/days supply)	After deductible, $18–90/90-day	

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