Plan Type (PPO or HMO)	PPO	PPO	PPO	HMO	PPO
Carrier (Anthem Blue Cross, Blue Shield, or Kaiser)	Blue Shield	Blue Shield	Blue Shield	Kaiser	Blue Shield

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

District Name — **The Palmdale Aerospace Academy- Effective 10/01/2025**

Bargaining Unit — **Certificated 2025-2026 Plan Comparison**

2025-2026	**Blue Shield**	**Blue Shield**	**Blue Shield**	**Kaiser**	**Blue Shield**
	100-B $20	**90-A $20**	**80-G $30 (Non-Marketed)**	**$10 OV, $10 Rx**	**2-Tier HSA $5,000**
SISC Cost Example Scenarios (PPO Plans Only)[1]					
Maternity Example	$120	$1,000	$2,000		$6,350
Diabetes Example	$120	$1,000	$2,000		$6,350
Fractured Foot Example	$120	$1,000	$2,000		$6,350
[1]Examples are based on the federal SBC examples, but updated with actual SISC Costs.					
MEDICAL - CALENDAR YEAR Deductibles &	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$100/$300	$100/$300	$500/$1,000	$0	$5,000/$10,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$1,500/$3,000	$6,350/$12,700*
					*Includes Rx
PROFESSIONAL SERVICES					
Primary Care* visit co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$20	$20	$30	$10	Deductible, then 30% after Ded
Urgent Care co-pay	$20	$20	$30	$10	30% after Ded
Prenatal, postnatal office visit co-pay	$20	$20	$30	$0	30% after Ded
Specialists/Consultants co-pay	$20	$20	$30	$10	30% after Ded
Scans: CT, CAT, MRI, PET etc.	0% after Ded	10% after Ded	20% after Ded	$0	30% after Ded
Laboratory Procedures	0% after Ded	10% after Ded	20% after Ded	$0	30% after Ded
Diagnostic X-rays	0% after Ded	10% after Ded	20% after Ded	$0	30% after Ded
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Co-pay applies	Not covered
Preventive Care (includes physical exams & screenings)	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	$0	0% after Ded Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit (copay waived if admitted) - **Avg Cost: $2,847 | $100+10%: $375 | $100+20%: $649**	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	$100	30% after Ded $100 co-pay
Inpatient Hospital (preauthorization required) - **Avg Cost for one day: $6,067 | 10%: $607 | 20%: $1,213**	0% after Ded	10% after Ded	20% after Ded	$0	30% after Ded
Surgery, Outpatient (performed in Surgery Center)	0% after Ded	10% after Ded	20% after Ded	$10	30% after Ded
Surgery, Outpatient (performed in a Hospital) - limits may apply	0% after Ded	10% after Ded	20% after Ded	$10	30% after Ded
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT					
INPATIENT: Facility Based Care (preauth required)	0% after Ded	10% after Ded	20% after Ded	$0	30% after Ded
OUTPATIENT: Facility Based Care (preauth required)	0% after Ded	10% after Ded	20% after Ded	$10	30% after Ded
OTHER SERVICES					
Ambulance (Ground or Air)	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	$50	30% after Ded $100 co-pay
Acupuncture - Limits apply	0% after Ded	10% after Ded	20% after Ded	$10/30 visits (through ASH) combined w/chiro	30% after Ded
Chiropractic - Limits apply	0% after Ded	10% after Ded	20% after Ded	$10/30 visits (through ASH) combined w/acu	30% after Ded
Physical and Occupational Therapy - Limits apply	0% after Ded	10% after Ded	20% after Ded	$10	30% after Ded
Durable Medical Equipment (DME)	0% after Ded	10% after Ded	20% after Ded	no charge	30% after Ded
Hearing Aids	Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	amount in excess of $500 allowance every 36 months	30% after Ded and Amount in excess of $700 allowance/24 months

*Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

PHARMACY BENEFITS

Plan	**Rx 9-35**	**Rx 9-35**	**Rx 9-35**	**$10 Rx**	**Rx HSA**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Kaiser	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco‡ $9 at Other Network	$0 at Costco‡ $9 at Other Network	$0 at Costco‡ $9 at Other Network	$10 up to 100 day supply	Deductible, then $0 at Costco or $9 at Other Network
Brand co-pay/30 days supply	$35	$35	$35	$10 up to 100 day supply	Deductible, then $35
Specialty co-pay/up to 30 days supply	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$10 up to 30 day supply	Deductible, then $35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$90‡	$0-$90‡	$0-$90‡	$10-$10/up to 100 day supply	Deductible, then $0-$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Costco Mail Order Pharmacy

This comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Employee cost/payroll deduction, if applicable, can be requested from the district.

‡Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

Delta Dental -$2,200/$2,000 and $2,000 Orthodontics	All medical plans come with the Delta Dental PPO Incentive Plan $2200 (Premier provider) $2000 (PPO Provider) annual maximum and $2,000 Orthodontics Lifetime Maximum				
Vison Service Plan (VSP)	All medical plans come with Vision Service Plan - VSP Plan B $20 co-pay (Exam, Lenses, and Frames every calendar year).				
2025-2026	**Composite**	**Composite**	**Composite**	**Composite**	**Single/2Party/Family**
Monthly Medical and Rx Premium	$1,921.00	$1,858.00	$1,580.00	$1,576.00	$650/ $1036/ $1036
Dental - DD 2000 annual max	$119.40	$119.40	$119.40	$119.40	$119.40
VSP Vision Plan B $20 copay	$21.50	$21.50	$21.50	$21.50	$21.50
Monthly Cost of Plan	**$2,061.90**	**$1,998.90**	**$1,720.90**	**$1,716.90**	**$790.90/ $1176.90/ $1176.90**
Annual (12thly) Cost of Plan	$24,742.80	$23,986.80	$20,650.80	$20,602.80	$9490.80/$14122.80/$14122.80
District Cap	$18,625.00	$18,625.00	$18,625.00	$18,625.00	18625.00
Annual Difference	$6,117.80	$5,361.80	$2,025.80	$1,977.80	-
Monthly Payroll Deduction (12thly)	$509.82	$446.82	$168.82	$164.82	$0/ $0/ $0
Initial in the box under the plan you wish to be enrolled					
	Initial	**Initial**	**Initial**	**Initial**	**Initial**

This is my Open Enrollment Election. I understand that I will remain enrolled on this plan until next open enrollment at which time I may elect to change to another medical plan unless I have a qualifying event that allows a change in plans and I notify my employer within 31-days. I also understand the plan I elected may require a payroll deduction. Please note: Payroll deduction is subject to change based on market prices. No change will be made without notification to employees.

PRINT NAME	**SIGNATURE**	**DATE**