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

The Palmdale Aerospace Academy

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

PACA — **11 month Classified**

2026-2027	**Blue Shield**	**Blue Shield**	**Blue Shield**	**Kaiser**	**Blue Shield**
	100-B $20	**90-E $20 (Non-Marketed)**	**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	$800	$800	$900		$5,120
Fractured Foot Example	$350	$990	$1,610		$5,080

[1]Examples are based on the federal SBC examples, but updated with actual SISC Costs.

MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$100/$300	$300/$600	$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
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	$2,102.00	$2,034.00	$1,730.00	$1,706.00	$740/ $1181/ $1181
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	**$2,242.90**	**$2,174.90**	**$1,870.90**	**$1,846.90**	**$880.90/$1321.90/$1321.90**
Annual (12thly) Cost of Plan	$26,914.80	$26,098.80	$22,450.80	$22,162.80	$10570.80/$15862.80/$15862.80
District Cap	$18,625.00	$18,625.00	$18,625.00	$18,625.00	18625.00
Annual Difference	$8,289.80	$7,473.80	$3,825.80	$3,537.80	0
Monthly Payroll Deduction (12thly)	$753.62	$679.44	$347.80	$321.62	$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**