*digital ID cards issued only

SISC 2026-2027 Plan Comparison - MGMT/CONF/SUPV Anthem Blue Cross Plan Options:	SISC 90-G PPO	SISC 80-G PPO	SISC 80-L PPO	SISC 100-A PPO	SISC Diamond Proactive Care PPO*	SISC Gold Proactive Care PPO*
MEDICAL - PLAN YEAR Deductible & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Annual Deductible (DED)	$500 per person $1000 family maximum	$500 per person $1000 family maximum	$2000 per person $4000 family maximum	None	None	None
Out-of-Pocket (OOP) Max includes medical deductibles, co-insurance and co-pays	$1000 per person $3000 family maximum	$2000 per person $4000 family maximum	$4000 per person $8000 family maximum	$1000 per person $3000 family maximum	$1000 per person $3000 family maximum	$3000 per person $6000 family maximum
PROFESSIONAL SERVICES						
Preventive Care	100% covered	100% covered	100% covered	100% covered	100% covered	100% covered
Primary Care Office Visit	$0 copay first 3 visits; $20 copay thereafter	$0 copay first 3 visits; $20 copay thereafter	$0 copay first 3 visits; $30 copay thereafter	$0 copay first 3 visits; $20 copay thereafter	$0 copay	$0 copay
Specialist/Consultant Visit	$20 copay	$20 copay	$30 copay	$20 copay	$40 copay	$100 copay
Urgent Care	$20 copay	$20 copay	$30 copay	$20 copay	$0 copay	$0 copay
Diagnostic X-ray & Laboratory Procedures	10%	20%	20%	100% covered	$0-$25 copay (office and freestanding labs)	$0-$75 (office and freestanding labs)
HOSPITAL & SKILLED NURSING FACILITY SERVICES						
Emergency Room Visit (copay waived if admitted)	$100 copay + DED then you pay 10%	$100 copay + DED then you pay 20%	$100 copay + DED then you pay 20%	$100 copay	$300 copay	$700 copay
Inpatient Hospital Care	DED then you pay 10%	DED then you pay 20%	DED then you pay 20%	100% covered	$200/day	$600/day
Outpatient Surgery	DED then you pay 10%	DED then you pay 20%	DED then you pay 20%	100% covered	$600 copay	$1800 copay
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
Inpatient Care: Facility Based Care (preauthorization required)	10%	20%	20%	100% covered	$200/day	$600/day
Outpatient Care: Facility Based Care (preauthorization required)	DED then you pay 10%	DED then you pay 20%	DED then you pay 20%	100% covered	100% covered	100% covered
OTHER SERVICES						
Acupuncture (limits apply)	10%	20%	20%	100% covered	100% covered	100% covered
Chiropractic (limits apply)	10%	20%	20%	100% covered	100% covered	100% covered
Physical & Occupational Therapy (limits apply)	10%	20%	20%	100% covered	100% covered	100% covered
Durable Medical Equipment (DME)	10%	20%	20%	100% covered	100% covered	100% covered
PHARMACY BENEFITS						
Generic*	$5 30-day	$5 30-day	$9 30-day	$5 30-day	$9 30-day	$9 30-day
Non-preferred brand drugs	$20 30-day	$20 30-day	$35 30-day	$20 30-day	$35 30-day	$35 30-day
Specialty	$20 30-day	$20 30-day	$35 30-day	$20 30-day	$35 30-day	$35 30-day
**Free generic medications at any Costco Pharmacy*					select brand medications at $0 when prescribed by a PCP	
PAYROLL DEDUCTION - 12THLY 7-8 HOURS						
Single	**$305.56**	**$223.56**	**$80.56**	**$429.56**	**$317.56**	**$149.56**
2Party	**$572.12**	**$402.12**	**$118.12**	**$830.12**	**$607.12**	**$260.12**
Family	**$741.46**	**$519.46**	**$150.46**	**$1,077.46**	**$787.46**	**$334.46**

This is a summary only. Please review the benefit summaries or plan booklets at https://www.anthem.com/ca/mcr/sisc for details, limitations, and exclusions.

*** RATES ARE SUBJECT TO CHANGE ***