

Santa Clara County Schools' Insurance Group
2027 Medical Plans



	KAISER PERMANENTE PLANS			UHC PLANS				
	Traditional HMO	Deductible HMO	Deductible HMO	Traditional HMO	Deductible HMO	Deductible HMO	High Deductible PPO HSA	
	HIGH PLAN	MID PLAN	LOW PLAN	HIGH PLAN	MID PLAN	LOW PLAN	PPO HSA PLAN	
	Kaiser HMO Plan Providers			UHC SignatureValue (Full Network) and UHC SignatureValue Alliance (Limited Network) HMO Providers			PPO Network	Non-PPO Network
Plan Details								
Annual Deductible* (Ind/Fam)	None	\$1,000/\$2,000	\$3,000/\$6,000	None	\$250/\$500	\$500/\$1,000	\$3,500/\$7,000	\$4,000/\$8,000
Out of Pocket Max** (Ind/Fam)	\$1,500/\$3,000	\$3,000/\$6,000	\$6,000/\$12,000	\$1,500/\$3,000	\$2,500/\$5,000	\$5,000/\$10,000	\$3,500/\$7,000	\$7,000/\$14,000
Benefit Details								
Preventive Care	\$0	\$0 (ded waived)	\$0 (ded waived)	\$0	\$0 (ded waived)	\$0 (ded waived)	\$0 (ded waived)	Not Covered
Office Visit	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$30 Copay (ded waived)	\$40 Copay (ded waived)	\$0 (after ded)	30% (after ded)
Diagnostic Lab & Xray	\$0	\$10 Copay (ded waived)	\$10 Copay (ded waived)	\$0	\$0	\$0	\$0 (after ded)	30% (after ded)
MRI, CT and PET scans	\$0	20% up to \$50 per procedure	30% up to \$50 per procedure	\$0	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Inpatient Hospital	\$0/admit	20% (after ded)	30% (after ded)	\$750/admit	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Outpatient Surgery	\$20 Copay	20% (after ded)	30% (after ded)	\$0	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Outpatient Rehab Therapy	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$30 Copay (ded waived)	\$40 Copay (ded waived)	\$0 (after ded) ¹¹	30% (after ded) ¹¹
Durable Medical Equipment	\$0	20% (ded waived)	20% (ded waived)	\$0	10% (after ded)	30% (after ded)	\$0 (after ded) ¹²	30% (after ded) ^{12,13}
Home Health Care	\$0 ⁵	\$0 (ded waived) ⁵	\$0 (ded waived) ⁵	\$30 Copay ⁸	\$30 Copay (ded waived) ⁹	\$40 Copay (ded waived) ⁹	\$0 (after ded) ¹⁴	30% (after ded) ¹⁴
Emergency Room	\$50 Copay ¹	20% (after ded)	30% (after ded)	\$150 Copay ¹	\$150 Copay (ded waived) ¹	\$250 Copay (ded waived) ¹	\$0 (after ded)	
Ambulance	\$50	\$150 (ded waived)	\$150 (ded waived)	\$0	10% (after ded)	20% (after ded)	\$0 (after ded)	30% (after ded) ¹⁵
Mental Health Outpatient	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$30 Copay (ded waived)	\$40 Copay (ded waived)	\$0 (after ded)	30% (after ded)
Mental Health Inpatient	\$0/admit	20% (after ded)	30% (after ded)	\$600/admit	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Acupuncture	Not Covered	Not Covered	Not Covered	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$0 (after ded) ¹⁶	30% (after ded) ¹⁶
Chiropractic	\$5 Copay ²	\$10 Copay (ded waived) ^{2,5}	\$10 Copay (ded waived) ^{2,5}	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$0 (after ded) ¹⁷	30% (after ded) ¹⁷
Prescription Drugs - Retail							Must satisfy Deductible before Rx copays apply	
Generic	\$10	\$10	\$10	\$10	\$10	\$10	\$10 (after ded)	\$10 (after ded)
Formulary Brand	\$20	\$30	\$30	\$25	\$30	\$30	\$30 (after ded)	\$30 (after ded)
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	\$40	\$50	\$50	\$50 (after ded)	\$50 (after ded)
Retail Supply	100-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Prescription Drugs - Mail Order								
Generic	\$10	\$20	\$20	\$10	\$10	\$10	\$20 (after ded)	Not Covered
Formulary Brand	\$20	\$60	\$60	\$50	\$60	\$60	\$60 (after ded)	Not Covered
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	\$80	\$100	\$100	\$100 (after ded)	Not Covered
Mail Order Supply	100-day supply	100-day supply	100-day supply	90-day supply	90-day supply	90-day supply	90-day supply	Not Covered

* All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

** All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

¹ Emergency copay waived if admitted to the hospital.

² Chiro limited to 20 visits/calendar year.

^{2,5} Chiro limited to 30 visits/calendar year.

³ Outpatient hospital benefit limited to \$350/admit when accessing care from a non-participating provider.

⁴ Physical therapy, physical medicine & occupational therapy, including chiropractic services limited to 24 visits per calendar year.

⁵ Up to 100 home health care visits per accumulation period

⁸ Home Health Care limited to 100 visits/calendar year; for infusion therapy, a separate \$40 per medication copay applies per 30 days

⁹ Home Health Care limited to 100 visits/calendar year; for infusion therapy, a separate \$50 per medication copay applies per 30 days

¹⁰ Limited to 40 visits combined for chiropractic and acupuncture

¹¹ Physical therapy, speech therapy & occupational therapy, including chiropractic services limited to 24 visits per calendar year.

¹² Limited to a single purchase of a type of durable medical equipment every three years

¹³ Prior Authorization required for Durable Medical Equipment that costs more than \$1,000

¹⁴ Home Health Care limited to 100 visits/calendar year

¹⁵ Coinsurance is only payable for non-emergency ambulance services

¹⁶ Acupuncture limited to 12 visits

¹⁷ Chiropractic limited to 24 visits

Disclaimer: The information described on this page is only intended to be a summary of your plans benefits. If the information on this page conflicts in any way with the Group Contract Agreement, the contract provisions of the appropriate policy or plan document will prevail.