Santa Clara County Schools' Insurance Group
2021 Medical Plans

	KAISER PERMANENTE PLANS			UHC PLANS				
	Traditional HMO HIGH PLAN	Deductible HMO MID PLAN	Deductible HMO LOW PLAN	Traditional HMO HIGH PLAN	Deductible HMO MID PLAN	Deductible HMO LOW PLAN	High Deductible PPO HSA PPO HSA PLAN	
	Kaiser HMO Plan Providers			*UHC SignatureValue (Full Network) and UHC SignatureValue Advantage (Limited Network) HMO Providers*			*PPO*	*Non-PPO*
Plan Details								
Annual Deductible (Ind/Fam)	None	$500 / $1,000	$3,000/$6,000	None	$250/$500	$500/$1,000	$2,800/$5,600	$3,000/$6,000
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	$2,800/$5,600	$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)*
Virtual Visits				$25 Copay *(ded waived)*	$20 Copay (ded waived)	$20 Copay (ded waived)		
Diagnostic Lab & Xray	$0	$10 Copay *(ded waived)*	$10 Copay *(ded waived)*	$0	$0	$0	$0 *(after ded)*	30% *(after ded)*
Inpatient Hospital	$500/admit	10% *(after ded)*	30% *(after ded)*	$750/admit	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	30% *(after ded)*
Outpatient Surgery	$20 Copay	10% *(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	20%	20% *(ded waived)*	20% *(ded waived)*	$0	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)* [12]	30% *(after ded)* [12]
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	$125 Copay [1]	10% *(after ded)*	30% *(after ded)*	$150 Copay [1]	$150 Copay *(ded waived)* [1]	$250 Copay *(ded waived)* [1]	$0 *(after ded)*	
Ambulance	$75	$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	$500/admit	10% *(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	$10 Copay [2]	$10 Copay *(ded waived)* [2]	$10 Copay *(ded waived)* [2]	$15Copay[10]	$15Copay[10]	$15Copay[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	$25	$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	31-day supply	31-day supply
Specialty	$35	$35	$35	Applicable Copay	Applicable Copay	Applicable Copay	Applicable Copay	Not Covered
Specialty Supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	31-day supply	Not Covered
Prescription Drugs - Mail Order								
Generic	$10	$20	$20	$10	$10	$10	$20 *(after ded)*	Not Covered
Formulary Brand	$25	$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

[1] *Emergency copay waived if admitted to the hospital.*
[2] *Only applicable of districts has elected Chiropractic/Acupuncture Benefit Rider. Chiro limited to 20 visits/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 are not applicble to limits. Out-of-Network benefits are limited to 24 combined visits.*
[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. Out-of-Network limited to $150 per visit*
[15] *Coinsurance is only payable for non-emergency ambulance services*
[16] *Acupuncture limited to 12 visits*
[17] *Chiropractic limited to 24 visits*

Santa Clara County Schools' Insurance Group
2021 Dental - Premium, High, & Low Plans

	Premium Plan
Deductibles	None
Maximums	Delta Dental PPO dentists: **$3,200/person/cal year** Non-Delta Dental PPO dentists: **$3,000/person/cal year**
Waiting Period(s)	None
Benefits & Covered Services*	**Delta Dental PPO dentists** / Non-Delta Dental PPO dentists****
Diagnostic and Preventive Services Exams,cleanings & x-rays # of Cleanings	70 - 100% **3**
Basic Services Fillings and sealants	70 - 100%
Endodontics (root canals) Covered under Basic Services	70 - 100%
Periodontics (gum treatment) Covered under Basic Services	70 - 100%
Oral Surgery Covered under Basic Services	70 - 100%
Major Services Crowns,inlays,onlays & cast restorations	70 - 100%
Prosthodontics Bridges & dentures	50% **(includes implants)**
Orthodontic Benefits	**Adult and Dependent Children** **50%**
Orthodontic Maximums	**$2,000 Lifetime**
Dental Accident Benefits	100% (separate $1,000 max/person/cal year)

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Santa Clara County Schools' Insurance Group
2021 Vision - Premium, High, Low Plans

	High Plan	
	In-Network	**Out-of-Network**
Benefit Frequency		
Exam	**Every 12 months**	
Lenses	**Every 12 months**	
Frames	**Every 24 months**	
Covered Services		
Exam	**$15 Copay** for exam & glasses	Up to $45 Reimbursement
Frames	Copay combined with exam, up to **$130 allowance;** 20% discount over allowance amount	Up to $47 Reimbursement
Lenses		
Single Vision	$0 Copay	Up to $45 Reimbursement
Lined Bifocal	$0 Copay	Up to $65 Reimbursement
Lined Trifocal	$0 Copay	Up to $85 Reimbursement
Progressive	$50-$160 Copay	Up to $85 Reimbursement
Contact Lenses	$0 Copay; Up to **$130** Allowance	Up to $105 Reimbursement