

SANTA CRUZ CITY SCHOOLS
 CABINET
 MONTHLY MEDICAL BENEFITS COST TABLE
 EFFECTIVE 10/01/16 - 9/30/17

	HMO PLANS			PPO PLANS	
CABINET	BLUE SHIELD HMO-\$30-20% #HSC2510	BLUE SHIELD *HMO-\$30-20% #NHS0090	BLUE SHIELD HMO-\$40-40% #HSC2620	BLUE SHIELD PPO-80-M \$40 #SC13840	BLUE SHIELD PPO-HSA-PLAN B #SC13850
Individual/Family Deductibles	N/A	N/A	N/A	\$3,000/\$6,000	\$3,000/\$5,000
Out of Pocket Maximum	\$1,500/\$3,000 20% Deductible	20% \$1,500/\$3,000 20% Deductible	20% \$3,500/\$7,000 40% Deductible	40% \$4,000/\$8,000	\$5,000/\$10,000
Office Visit Co-Pay	\$30 office	\$30 office	\$40 office	\$40 office	10% - Out of Pocket Maximum
Prescription Drug Plans	\$9/\$35 RX	\$9/\$35 RX	\$200 RX Deductible then \$9/\$35 RX	\$9/\$35 RX	10% - Out of Pocket Maximum then \$9/\$35RX
Network	Full Network	*PMG Only No PAMF	Full Network	Full Network	Full Network
EMPLOYEE MONTHLY COST					
COMPOSITE RATE	\$ 718.20	\$ 709.80	\$ 679.80	\$ 619.90	\$ 640.80

The employee's share costs are negotiated annually by your Meet and Confer Group and therefore are subject to change.



Santa Cruz City Schools - CABINET & MANAGEMENT - SISC Blue Shield Plans Comparison - Effective October 1, 2015

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) 30-20%, Rx 9-35	Blue Shield SAVENET HMO 30-20%, Rx 9-35	Blue Shield HMO-Full (includes PAMF) 40-40%, Rx 10/200-35	Blue Shield PPO 80-M \$40, Rx 9-35	Blue Shield PPO HDHP - HSA- Plan B			
GROUP NUMBER	HSC2510 \$30-20%	NHS0090 \$30-20%	HSC2620 40-40%	SC13840 80-M \$40	SC13850 HSA-Plan B			
	Member Pays		Member Pays		Member Pays		Member Pays	
Individual/Family Deductibles	\$0/\$0	\$0/\$0	\$0/\$0	\$3,000/\$6,000	\$3,000/\$5,000			
Individual/Family Calendar Out-of-Pocket Max <i>(includes medical co-pays, deductibles and co-insurance)</i>	\$1,500/\$3,000	\$1,500/\$3,000	\$3,500/\$7,000	\$4,000/\$8,000	\$5,000/\$10,000			
PROFESSIONAL SERVICES								
Office Visit co-pay	\$30	\$30	\$40	\$40	10%			
Urgent Care co-pay	\$30	\$30	\$40	\$40	10%			
Specialists/Consultants co-pay	\$45	\$45	\$50	\$40	10%			
Prenatal, postnatal office visit co-pay	\$30	\$30	\$40	\$40	10%			
Scans: CT, CAT, MRI, PET etc.	\$0	\$0	\$0	20%	10%			
Diagnostic X-ray & Laboratory Procedures	\$0	\$0	\$0	20%	10%			
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	50%	Not covered	Not covered			
Preventive Care Services (includes physical exams & screenings)	\$0	\$0	\$0	0%, Deductible Waived	0%, Ded Waived			
HOSPITAL & SKILLED NURSING FACILITY SERVICES								
Emergency Room visit co-pay (waived if admitted)	\$150	\$150	\$200	20% \$100 co-pay	10% \$100 co-pay			
Inpatient Hospital co-pay (preauthorization required)	20%	20%	40%	20%	10%			
Outpatient Hospital co-pay	\$0	\$0	40%	20%	10%			
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	\$0	\$0	40%	20%	10%			
Surgery, Outpatient (performed in a Hospital)	\$0	\$0	40%	20%	10%			
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT								
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	40%	20%	10%			
OUTPATIENT CARE: Facility based care (preauthorization required)	\$30	\$30	\$40	\$40	10%			
OTHER SERVICES								
Acupuncture - Limits apply	\$10/30 visits combined w/chiro Use ASH network	\$10/30 visits combined w/chiro Use ASH network	\$10/30 visits combined w/chiro Use ASH network	20%	10%			
Ambulance (Ground or Air)	\$100	\$100	\$100	20%	10%			
Chiropractic - Limits apply	\$10/30 visits combined w/acu Use ASH Network	\$10/30 visits combined w/acu Use ASH Network	\$10/30 visits combined w/acu Use ASH Network	20%	10%			
Durable Medical Equipment (DME)	20%	20%	40%	20%	10%			
Physical and Occupational Therapy - Limits apply	\$30	\$30	\$40	20%	10%			
PRESCRIPTION DRUG PLANS								
Provider Network	Navitus	Navitus	Navitus	Navitus	Blue Shield			
Generic co-pay/days supply	\$9 / 30-day	\$9 / 30-day	\$10 / 30-day	\$9 / 30-day	After Medical deductible, \$9/ 30-day			
Brand co-pay/days supply	\$35 / 30-day	\$35 / 30-day	\$35 / 30-day	\$35 / 30-day	After medical deductible, \$35/30-day			
Prescription Deductible Brand Drugs Only (ind/family)	No Rx Deductible	No Rx Deductible	\$200 / \$500	No Rx Deductible	Medical Ded. Applies			
Mail Order (Generic-Brand co-pay/days supply)	\$0 - \$90 / 90-day	\$0 - \$90 / 90-day	\$0 - \$90 / 90-day	\$0 - \$90 / 90-day	After medical deductible, \$18-35/90-day			
Prescription Drug Out-of-Pocket Maximum	\$2,500 / \$3,500	\$2,500 / \$3,500	\$2,500 / \$3,500	\$2,500 / \$3,500	Medical OOP Maximum applies			

Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet. Plans with a deductible all have 4th quarter deductible carryover (October 1-December 31) except for the HDHP-HSA plan. Co-pays and co-insurance do not carryover to the next calendar year. To find a participating or contracting provider call the customer service number on your ID card or visit www.blueshieldca.com Pharmacy benefits have separate OOP Maximums when covered through Navitus.