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

	HMO PLANS			PPO PLANS		
CERTIFICATED EMPLOYEES	BLUE SHIELD HMO-$30-20% **#HSC2230**	BLUE SHIELD *HMO-$30-20% **#NHS0080**	BLUE SHIELD HMO-$40-40% **#HSC2220**	BLUE SHIELD PPO-80-M $40 **#SC10920**	BLUE SHIELD PPO-HSA-PLAN B **#SC10930**	BLUE SHIELD PPO-MINIMUM VALUE **#SCB1250**
Individual/Family Deductibles	N/A	N/A	N/A	$3,000/$6,000	$3,000/$5,000	$5,000/$10,000
Out of Pocket Maximum	$1,500/$3,000 20% Deductable	$1,500/$3,000 20% Deductable	$3,500/$7,000 40% Deductable	$4,000/$8,000	$5,000/$10,000	$6,350/$12,700
Office Visit Co-Pay	$30 office	$30 office	$40 office	$40 office	10% - Out of Pocket Maximum	$60 office 1 - 3 visits thereafter deductible
Prescription Drug Plans	$9/$35 RX	$9/$35 RX	$200 RX Deductible then $10/$35 RX	$9/$35 RX	10% - Out of Pocket Maximum then $9/$35 RX	30% - Out of Pocket Maximum then $9/$35 RX
Network	Full Network	*PMG Only No PAMF	Full Network	Full Network	Full Network	Full Network
FULL TIME EMPLOYEE (1.0 FTE) MONTHLY COST						
SINGLE (EMPLOYEE ONLY)	$ 377.00	$ 364.10	$ 356.10	$ 348.20	$ 360.40	$ 313.70
TWO PARTY (EMPLOYEE + ONE)	$ 738.20	$ 712.50	$ 699.60	$ 648.40	$ 681.30	$ 592.60
FAMILY (EMPLOYEE + TWO OR MORE)	$ 1,037.70	$ 1,001.10	$ 985.10	$ 955.80	$ 1,027.50	$ 893.60
PART TIME EMPLOYEE (.50 -.99 FTE) MONTHLY COST						
SINGLE (EMPLOYEE ONLY)	$ 377.00	$ 364.10	$ 356.10	$ 348.20	$ 360.40	$ 313.70
TWO PARTY (EMPLOYEE + ONE	$ 789.05	$ 761.74	$ 747.27	$ 693.62	$ 727.60	$ 632.88
FAMILY (EMPLOYEE + TWO OR MORE)	$ 1,109.20	$ 1,070.29	$ 1,052.23	$ 1,022.58	$ 1,097.43	$ 954.43

The employee's share costs are negotiated annually by your union and therefore are subject to change.
Your cost will be deducted from your payroll check in 10 equal installments starting in October. As the withdraw will be done in 10 installments, it will be higher than the amount stated in the table.

SISC III

Santa Cruz City Schools - Certificated - SISC Blue Shield Plans Comparion - 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	Blue Shield PPO Minimum Value Plan	Blue Shield PPO 2-Tiered Anchor Bronze
GROUP NUMBER	HSC2230 $30-20%	NHS0080 $30-20%	HSC2220 40-40%	SC1092 80-M $40	SC1093 HSA-Plan B	SCB125 MINIMUM VALUE	ANCHOR BRONZE (no dental, vision or spouse coverage)
	Member Pays	Member Pays	Member Pays	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	$5,000/$10,000	$5,000/$10,000
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	$1,500/$3,000	$1,500/$3,000	$3,500/$7,000	$4,000/$8,000	$5,000/$10,000	$6,350/$12,700	$6,350/$12,700
PROFESSIONAL SERVICES							
Office Visit co-pay	$30	$30	$40	$40	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Urgent Care co-pay	$30	$30	$40	$40	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Specialists/Consultants co-pay	$45	$45	$50	$40	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Prenatal, postnatal office visit co-pay	$30	$30	$40	$40	10%	$60 vists 1-3, then 30% after ded	$60 vists 1-3, then 30% after ded
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	20%	10%	30%	30%
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	20%	10%	30%	30%
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	50%	Not covered	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0	0%, Deductible Waived	0%, Ded Waived	0%, Ded 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	30% $100 co-pay	30% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	20%	20%	40%	20%	10%	30%	30%
Outpatient Hospital co-pay	$0	$0	40%	20%	10%	30%	30%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$0	$0	40%	20%	10%	30%	30%
Surgery, Outpatient (performed in a Hospital)	$0	$0	40%	20%	10%	30%	30%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT							
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	40%	20%	10%	30%	30%
OUTPATIENT CARE: Facility based care (preauthorization required)	$30	$30	$40	$40	10%	30%	30%
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%	30%	30%
Ambulance (Ground or Air)	$100	$100	$100	20%	10%	30%	30%
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%	30%	30%
Durable Medical Equipment (DME)	20%	20%	40%	20%	10%	30%	30%
Physical and Occupational Therapy - Limits apply	$30	$30	$40	20%	10%	30%	30%
PRESCRIPTION DRUG PLANS							
Provider Network	Navitus	Navitus	Navitus	Navitus	Blue Shield	Blue Shield	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	After Medical deductible, $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	After medical deductible, $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	Medical Ded. Applies	Medical Deductible 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	After medical deductible, $18-90/90-day	After medical deductible, $18-90/90-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	Medical OOP Maximum applies	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. No District contribution will be made for the Blue Shield PPO Anchor Bronze Plan.