SANTA CRUZ CITY SCHOOLS
MANAGEMENT
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/17 - 9/30/18

	HMO PLANS				PPO PLANS	
MANAGEMENT	BLUE SHIELD HMO-$30-20% #1H011002	BLUE SHIELD *HMO-$30-20% #1H071002	BLUE SHIELD HMO-$40-40% #1H051002	KAISER HMO-$30-0 #605337-0005	BLUE SHIELD PPO-80-M $40 #0P011002	BLUE SHIELD PPO-HSA-PLAN B #0P021008
Individual/Family Deductibles	N/A	N/A	N/A	N/A	$3,000/$6,000	$3,000/$5,000
Out of Pocket Maximum	$1,500/$3,000 20% Deductable	20% I $1,500/$3,000 20% Deductable	$3,500/$7,000 40% Deductable	$1,500/$3,000	$4,000/$8,000	$5,000/$10,000
Office Visit Co-Pay	$30 office	$30 office	$40 office	$30 office	$40 office	10% - Out of Pocket Maximum
Prescription Drug Plans	$9/$35 RX	$9/$35 RX	$200 RX Deductible then $10/$35	$10/$30 RX	$9/$35 RX	10% - Out of Pocket Maximum then $9/$35 RX
Network	Full Network	*PMG Only No PAMF	Full Network	KAISER	Full Network	Full Network
FULL TIME EMPLOYEE MONTHLY COST						
COMPOSITE RATE	$ 761.40	$ 717.30	$ 697.20	$ 721.50	$ 651.10	$ 675.00
PART TIME EMPLOYEE MONTHLY COST						
COMPOSITE RATE	$ 832.25	$ 796.55	$ 764.37	$ 773.74	$ 724.82	$ 760.30

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
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/17 - 9/30/18

	HMO PLANS				PPO PLANS	
CABINET	BLUE SHIELD HMO-$30-20% #1H011002	BLUE SHIELD *HMO-$30-20% #1H071002	BLUE SHIELD HMO-$40-40% #1H051002	KAISER HMO-$30-0 #605337-0005	BLUE SHIELD PPO-80-M $40 #0P011002	BLUE SHIELD PPO-HSA-PLAN B #0P021008
Individual/Family Deductibles	N/A	N/A	N/A	N/A	$3,000/$6,000	$3,000/$5,000
Out of Pocket Maximum	$1,500/$3,000 20% Deductable	20% I $1,500/$3,000 20% Deductable	$3,500/$7,000 40% Deductable	$1,500/$3,000	$4,000/$8,000	$5,000/$10,000
Office Visit Co-Pay	$30 office	$30 office	$40 office	$30 office	$40 office	10% - Out of Pocket Maximum
Prescription Drug Plans	$9/$35 RX	$9/$35 RX	$200 RX Deductible then $10/$35 RX	$10/$30 RX	$9/$35 RX	10% - Out of Pocket Maximum then $9/$35 RX
Network	Full Network	*PMG Only No PAMF	Full Network	KAISER	Full Network	Full Network
EMPLOYEE MONTHLY COST						
COMPOSITE RATE	$ 761.40	$ 717.30	$ 697.20	$ 721.50	$ 651.10	$ 675.00

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

SISC III

Santa Cruz City Schools - CABINET & MANAGEMENT - SISC Blue Shield Plans Comparion - Effective October 1, 2016

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	Kaiser HMO $30-0, Rx 10-30	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%	605337 $30-0	SC13840 80-M $40	SC13850 HSA-Plan B		
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays		
Individual/Family Deductibles	$0/$0	$0/$0	$0/$0	$0/$0	$3,000/$6,000	$3,000/$5,000		
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	$1,500/$3,000	$4,000/$8,000	$5,000/$10,000		
PROFESSIONAL SERVICES								
Office Visit co-pay	$30	$30	$40	$30	$40	10%		
Urgent Care co-pay	$30	$30	$40	$30	$40	10%		
Specialists/Consultants co-pay	$45	$45	$50	$30	$40	10%		
Prenatal, postnatal office visit co-pay	$30	$30	$40	$30	$40	10%		
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	$0	20%	10%		
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	$0	20%	10%		
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	50%	Not covered	Not covered	Not covered		
Preventive Care Services (includes physical exams & screenings)	$0	$0	$0	$0	0%, Deductible Waived	0%, Dec Waived		
HOSPITAL & SKILLED NURSING FACILITY SERVICES								
Emergency Room visit co-pay (waived if admitted)	$150	$150	$150	$100	20% $100 co-pay	10% $100 co-pay		
Inpatient Hospital co-pay (preauthorization required)	20%	20%	40%	$0	20%	10%		
Outpatient Hospital co-pay	$30	$30	$40	$30	20%	10%		
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$0	$0	$0	N/A	20%	10%		
Surgery, Outpatient (performed in a Hospital)	$0	$0	$0	$30	20%	10%		
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT								
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	40%	$0	20%	10%		
OUTPATIENT CARE: Facility based care (preauthorization required)	$30	$30	$40	$30	$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	$10/30 visits combined w/chiro Use ASH network	20%	10%		
Ambulance (Ground or Air)	$100	$100	$100	$50	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	$10/30 visits combined w/acu Use ASH Network	20%	10%		
Durable Medical Equipment (DME)	20%	20%	40%	$0	20%	10%		
Physical and Occupational Therapy - Limits apply	$30	$30	$40	$30	20%	10%		
PRESCRIPTION DRUG PLANS								
Provider Network	Navitus	Navitus	Navitus	Navitus	Navitus	Blue Shield		
Generic co-pay/days supply	$9 / 30-day	$9 / 30-day	$10 / 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	$30 / 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	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	$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	$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.