

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

CERTIFICATED EMPLOYEES	HMO PLANS				PPO PLANS		
	BLUE SHIELD HMO-\$30-20% #1H011000	BLUE SHIELD *HMO-\$30-20% #1H071000	BLUE SHIELD HMO-\$40-40% #1H051000	KAISER HMO-\$30-0 #605337-0004	BLUE SHIELD PPO-80-M \$40 #0P011010	BLUE SHIELD PPO-HSA-PLAN B #0P021000	BLUE SHIELD PPO-MINIMUM VALUE #0P041003
Individual/Family Deductibles	N/A	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	\$1,500/\$3,000	\$4,000/\$8,000	\$5,000/\$10,000	\$6,350/\$12,700
Office Visit Co-Pay	\$30 office	\$30 office	\$40 office	\$30 office	\$40 office	10% - Out of Pocket Maximum	\$60 office after deductible is met
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	30% - Out of Pocket Maximum then \$9/\$35 RX
Network	Full Network	*PMG Only No PAMF	Full Network	KAISER	Full Network	Full Network	Full Network
<b>FULL TIME EMPLOYEE (1.0 FTE) MONTHLY COST</b>							
SINGLE (EMPLOYEE ONLY)	\$ 399.20	\$ 372.80	\$ 365.10	\$ 364.40	\$ 359.90	\$ 372.40	\$ 326.30
TWO PARTY (EMPLOYEE + ONE)	\$ 782.30	\$ 730.20	\$ 717.30	\$ 711.60	\$ 673.90	\$ 708.30	\$ 620.50
FAMILY (EMPLOYEE + TWO OR MORE)	\$ 1,100.40	\$ 1,025.70	\$ 1,010.00	\$ 1,000.20	\$ 988.20	\$ 1,061.70	\$ 929.90
<b>PART TIME EMPLOYEE (.50 -.99 FTE) MONTHLY COST</b>							
SINGLE (EMPLOYEE ONLY)	\$ 399.20	\$ 372.80	\$ 365.10	\$ 364.40	\$ 359.90	\$ 372.40	\$ 326.30
TWO PARTY (EMPLOYEE + ONE)	\$ 833.15	\$ 779.44	\$ 764.97	\$ 760.84	\$ 719.12	\$ 754.60	\$ 660.78
FAMILY (EMPLOYEE + TWO OR MORE)	\$ 1,171.90	\$ 1,094.89	\$ 1,077.13	\$ 1,069.39	\$ 1,054.98	\$ 1,131.63	\$ 990.73

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.



Santa Cruz City Schools - Certified - SISC Blue Shield & Kaiser Plans Comparison - Effective October 1, 2017

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	Blue Shield PPO Minimum Value Plan	Blue Shield PPO 2-Tiered Anchor Bronze
GROUP NUMBER	HSC2230 \$30-20%	NHS0080 \$30-20%	HSC2220 \$40-40%	605337 \$30-0	SC1092 80-M \$40	SC1093 HSA-Pan 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	Member Pays
Individual/Family Deductibles	\$0/\$0	\$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	\$1,500/\$3,000	\$4,000/\$8,000	\$5,000/\$10,000	\$6,350/\$12,700	\$6,350/\$12,700
<b>PROFESSIONAL SERVICES</b>								
Office Visit co-pay	\$30	\$30	\$40	\$30	\$40	10%	\$60 visits 1-3, then 30% after ded	\$60 visits 1-3, then 30% after ded
Urgent Care co-pay	\$30	\$30	\$40	\$30	\$40	10%	\$60 visits 1-3, then 30% after ded	\$60 visits 1-3, then 30% after ded
Specialists/Consultants co-pay	\$45	\$45	\$50	\$30	\$40	10%	\$60 visits 1-3, then 30% after ded	\$60 visits 1-3, then 30% after ded
Prenatal, postnatal office visit co-pay	\$30	\$30	\$40	\$30	\$40	10%	\$60 visits 1-3, then 30% after ded	\$60 visits 1-3, then 30% after ded
Scans: CT, CAT, MRI, PET etc.	\$0	\$0	\$0	\$0	20%	10%	30%	30%
Diagnostic X-ray & Laboratory Procedures	\$0	\$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	Not covered
Preventive Care Services (includes physical exams & screenings)	\$0	\$0	\$0	\$0	0%, Deductible Waived	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived
<b>HOSPITAL &amp; SKILLED NURSING FACILITY SERVICES</b>								
Emergency Room visit co-pay (waived if admitted)	\$150	\$150	\$200	\$100	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%	\$0	20%	10%	30%	30%
Outpatient Hospital co-pay	\$30	\$30	\$40	\$30	20%	10%	30%	30%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	\$0	\$0	\$0	N/A	20%	10%	30%	30%
Surgery, Outpatient (performed in a Hospital)	\$0	\$0	\$0	\$30	20%	10%	30%	30%
<b>MENTAL HEALTH SERVICES &amp; SUBSTANCE ABUSE TREATMENT</b>								
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	40%	\$0	20%	10%	30%	30%
OUTPATIENT CARE: Facility based care (preauthorization required)	\$30	\$30	\$40	\$30	\$40	10%	30%	30%
<b>OTHER SERVICES</b>								
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%	30%	30%
Ambulance (Ground or Air)	\$100	\$100	\$100	\$50	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	\$10/30 visits combined w/acu Use ASH Network	20%	10%	30%	30%
Durable Medical Equipment (DME)	20%	20%	40%	\$0	20%	10%	30%	30%
Physical and Occupational Therapy - Limits apply	\$30	\$30	\$40	\$30	20%	10%	30%	30%
<b>PRESCRIPTION DRUG PLANS</b>								
Provider Network	Navitus	Navitus	Navitus	Navitus	Navitus	Blue Shield	Blue Shield	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	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	\$30 / 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	No Rx Deductible	Medical Ded. Applies	Medical Ded. Applies	Medical Deductible Annies
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	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	\$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](http://www.blueshieldca.com). Pharmacy benefits have separate OOP Maximums when covered through Navitus.