SANTA CRUZ CITY SCHOOLS

CLASSIFIED/CONFIDENTIAL EMPLOYEE

MONTHLY MEDICAL BENEFITS COST TABLE

EFFECTIVE 10/01/17 - 9/30/18

	HMO PLANS			PPO PLANS	
CLASSIFIED EMPLOYEES	BLUE SHIELD HMO 25-500 #1H031001	BLUE SHIELD HMO 25-500 SaveNet #1H081001	KAISER HMO 0-0 #605337-0006	BLUE SHIELD PPO 90-E $20 #0P031001	BLUE SHIELD PPO 80-K $30 #0P051001
Individual/Family Deductibles	N/A	N/A	N/A	$300/$600	$1,000/$2,000
Out of Pocket Maximum	$2,000/$4,000 20% Deductible	$2,000/$4,000 20% Deductible	$1,500/$3,000	$1,000/$3,000	$3,000/$6,000
Office Visit Co-Pay	$25	$25	$0	$20	$30
Prescription Drug Plans (Out of Pocket Maximum)	$5/$20 RX, $1,500/$2,500	$5/$20 RX, $1,500/$2,500	$5/$5 RX, $1,500/$3,000	$7/$25 RX, $1,500/$2,500	$5/$20 RX, $1,500/$2,500
Network	Full Network	PMG Only No PAMF	KAISER ONLY	Full Network	Full Network
FULL TIME EMPLOYEE (.875-1.0 FTE) MONTHLY COST					
SINGLE (EMPLOYEE ONLY)	$0.00	$0.00	$0.00	$129.80	$0.00
TWO PARTY (EMPLOYEE + ONE	$0.00	$0.00	$0.00	$199.70	$0.00
FAMILY (EMPLOYEE + TWO OR MORE)	$0.00	$0.00	$0.00	$422.70	$35.70
PART TIME EMPLOYEE (.50-.870 FTE) MONTHLY COST					
SINGLE (EMPLOYEE ONLY)	$0.00	$0.00	$0.00	$129.80	$0.00
TWO PARTY (EMPLOYEE + ONE	$6.57	$0.00	$0.00	$256.57	$0.00
FAMILY (EMPLOYEE + TWO OR MORE)	$101.68	$0.00	$0.00	$579.68	$192.68

Classified employee's share costs are negotiated annually by your union and therefore are subject to change.

Confidential employee's share costs are negotiated annually by your Meet and Confer Group 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. 12 month employee will be taken out over 12 months.

SISC III

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

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) $25 CO PAY, Rx 5-20	Blue Shield SAVENET HMO $25 CO PAY, Rx 5-20	Kaiser HMO $0 CO PAY, Rx 5-5	Blue Shield PPO 90-E $20, Rx 7-25	Blue Shield PPO 80-K $30, Rx 5-20
GROUP NUMBER	1H031001	1H081001	605337	0P031001	0P051001
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	$0/$0	$0/$0	$0/$0	$300/$600	$1,000/$2,000
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	$2,000/$4,000	$2,000/$4,000	$1,500/$3,000	$1,000/$3,000	$3,000/$6,000
PROFESSIONAL SERVICES					
Office Visit co-pay	$25	$25	$0	$20	$30
Urgent Care co-pay	$25	$25	$0	$20	$30
Specialists/Consultants co-pay	$30	$30	$0	$20	$30
Prenatal, postnatal office visit co-pay	$25	$25	$0	$20	$30
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	10%	20%
Diagnostic X-ray & Laboratory Procedures	$0	$0	$0	10%	20%
Infertility (diagnosis/treatment of causes of infertility)	50%	50%	Not covered	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)	$100	$100	$100	10% $100 co-pay	20% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	$500	$500	$0	10%	20%
Outpatient Hospital co-pay	$300	$300	$0	10%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$150	$150	N/A	10%	20%
Surgery, Outpatient (performed in a Hospital)	$300	$300	$0	10%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					20%
INPATIENT CARE: Facility based care (preauthorization required)	$500	$500	$0	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	$25	$25	$0	10%	20%
OTHER SERVICES					20%
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%	20%
Ambulance (Ground or Air)	$100	$100	$50	10%	20%
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%	20%
Durable Medical Equipment (DME)	20%	20%	$0	10%	20%
Physical and Occupational Therapy - Limits apply	$25	$25	$0	10%	20%
PRESCRIPTION DRUG PLANS					
Provider Network	Navitus	Navitus	Navitus	Navitus	Blue Shield
Generic co-pay/days supply	$5 / 30-day	$5 / 30-day	$5 / 30-day	$7 / 30-day	$5 / 30-day
Brand co-pay/days supply	$20 / 30-day	$20 / 30-day	$5 / 30-day	$25 / 30-day	$20 / 30-day
Prescription Deductible Brand Drugs Only (ind/family)	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible	No Rx Deductible
Mail Order (Generic-Brand co-pay/days supply)	$0 - $90 / 90-day	$0 - $90 / 90-day	$0 - $15 / 90-day	$0 - $90 / 90-day	$0 - $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

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.