SANTA CRUZ CITY SCHOOLS
CABINET & MANAGEMENT
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2023 - 9/30/2024

HMO PLANS

	SUTTER HEALTH PLUS HMO $30-20% PLAN ID: SHPML65	SUTTER HEALTH PLUS HMO $40-40% PLAN ID: SHPML66	KAISER HMO $30-0 PLAN ID: HMOK
Individual/Family Deductibles			
Out of Pocket Maximum	$2,000/$4,000	$3,000/$6,000	$1,500/$3,000
Office Visit Co-Pay	$30	$40	$30
Prescription Drug Plans (Out of Pocket Maximum)	$10/$30 RX, $1,500/$2,500	$10/$30 RX, $1,500/$2,500	$10/$30 RX, $1,500/$3,000
Network	Full Network	Full Network	KAISER ONLY

Monthly Premium		Monthly Premium		Monthly Premium	
SINGLE	$797.80	SINGLE	$771.80	SINGLE	$789.95
2-PARTY	$1,555.40	2-PARTY	$1,504.80	2-PARTY	$1,579.89
FAMILY	$2,185.40	FAMILY	$2,114.20	FAMILY	$2,235.55

FULL TIME EMPLOYEE (1.0 FTE) MONTHLY CONTRIBUTION	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	$505.73	$292.07	$509.14	$262.66	$434.59	$355.36
TWO PARTY (EMPLOYEE + ONE)	$982.97	$572.43	$990.51	$514.29	$864.57	$715.32
FAMILY (EMPLOYEE + TWO OR MORE)	$1,379.88	$805.52	$1,391.31	$722.89	$1,226.15	$1,009.40

PART TIME EMPLOYEE (0.5-0.9 FTE) MONTHLY CONTRIBUTION	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	$505.73	$292.07	$509.14	$262.66	$434.59	$355.36
TWO PARTY (EMPLOYEE + ONE)	$932.12	$623.28	$942.84	$561.96	$815.33	$764.56
FAMILY (EMPLOYEE + TWO OR MORE)	$1,308.38	$877.02	$1,324.18	$790.02	$1,156.96	$1,078.59

CERTIFICATED MGMT & CABINET	Monthly Premium
DENTAL INCENTIVE PPO	$121.40
DELTA DENTAL UNLIMITED PPO	$130.90
MANAGEMENT - VSP	$17.00
LIFE INSURANCE	$21.42

**Monthly contributions will be deducted from your payroll check in 12 equal installments starting in August.

CLASSIFIED MGMT & CABINET	Monthly Premium
DENTAL INCENTIVE PPO	$121.40
DELTA DENTAL UNLIMITED PPO	$130.90
MANAGEMENT - VSP	$17.00
LIFE INSURANCE	$21.42
LONG TERM DISABILITY	$59.76

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

Santa Cruz City Schools Medical Plan Comparison Cabinet & Management
Effective October 1, 2023- September 30, 2024

Sutter Health Plus Your Health Plan / KAISER PERMANENTE	SHP - Summit ML65 HMO $30-20%, Rx 10-30 Payroll ID: SHPML65	SHP - Summit ML66 HMO $40-40%, Rx $10-30 Payroll ID: SHPML66	Kaiser HMO $30-0, Rx 10-30 Payroll ID: HMOK
	Member Pays	**Member Pays**	**Member Pays**
COPAY & COINSURANCE	$30-20%	$40-40%	$30-0
Individual/Family Deductibles	**$0/$0**	**$0/$0**	**$0/$0**
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	**$2,000/$4,000**	**$3,000/$6,000**	**$1,500/$3,000**
Preventive Care Services (includes physical exams & screenings)			
Annual Eye Exam for Refraction	**No Charge**	**No Charge**	**No Charge**
Family Planning Counseling & Services (Preconception Care Visits)	**No Charge**	**No Charge**	**No Charge**
Immunizations/Vaccines	**No Charge**	**No Charge**	**No Charge**
Routine Preventive Medical Exams, Procedures & Screenings	**No Charge**	**No Charge**	**No Charge**
Routine Preventive Imaging and Lab Services	**No Charge**	**No Charge**	**No Charge**
Preventive Care Rx, Supplies, Equipment & Supplements	**No Charge**	**No Charge**	**No Charge**
Outpatient Services			
Office Visit - Primary Care Physician (PCP) for illness or injury	**$30**	**$40**	**$30**
Other Practitioner Visit	**$30**	**$40**	**$30**
Sutter Walk-in Care visit	**$30**	**$40**	**N/A**
Specialist Office Visit	**$30**	**$40**	**$30**
Allergy Services (includes testing, injections, and serum)	**$30**	**$40**	**No Charge**
Medically administered drugs dispensed by a PCP for adminsitration	**No Charge**	**No Charge**	**No Charge**
Outpatient Rehabilitation Services	**$30**	**$40**	**$30**
Outpatient Habilitation Services	**Not Covered**	**Not Covered**	**$30**
Outpatient Surgery Facility Fee	**$100 Copay per visit**	**$100 Copay per visit**	**$30 per procedure**
Outpatient Surgery Professional Fee	**No Charge**	**No Charge**	**No Charge**
Outpatient Visit (non-office visit)	**$60**	**$80**	**N/A**
Non-prevenitive Lab Services	**$10**	**$10**	**No Charge**
Radiological & Nuclear Imaging (MRI, CT, and PET Scans)	**$50**	**$50**	**No Charge for most Scans**
Diagnostic & Therapeutic Imaging & Testing (x-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test & cardiac monitoring	**$10**	**$10**	**No Charge for most Testing**
Hospitalization Services			
Inpatient Facility Fee(hospital room, medical supplies, & inpatient drugs including anesthesia)	**$500**	**$500**	**No Charge**
Inpatient Professional Fees (surgeon and anesthesiologist)	**No Charge**	**No Charge**	**No Charge**
Emergency & Urgent Care Services			
Emergency Room Facility Fee	**$150**	**$150**	**$100 (Waived if Admitted)**
Urgent Care - consultations, exams, and treatments	**$40**	**$40**	**$30**
Ambulance Services - *Medical Transportation*	**$100/ per trip**	**$150/ per trip**	**$50/ per trip**
Durable Medical Equipment (DME)	**20% Coinsurance**	**20% Coinsurance**	**No Charge**
Mental/ Behavioral Health & Substance Use Disorder (MH/SUD)			
MH/SUD Inpatient Facility Fee	**$500 copay per admission**	**$500 copay per admission**	**No Charge**
MH/SUD Inpatient Professional Fees	**No Charge**	**No Charge**	**No Charge**
MH/SUD Individual outpatient Office Visits	**$30**	**$40**	**$30**
MH/SUD Group outpatient Office Visits	**$15**	**$20**	**$5**
MH/SUD Other Outpatient Services	**$60**	**$80**	**N/A**
Home Health Services			
Home Health Care (up to 100 visits per calendar year)	**No Charge**	**No Charge**	**No Charge**
Maternity Care			
Routine Prenatal Care Visits & First Postnatal Visits	**No Charge**	**No Charge**	**No Charge**
Breastfeeding Counseling Services & Supplies	**No Charge**	**No Charge**	**No Charge**
Labor & Delivery Inpatient Facility Fee	**$500 copay per admission**	**$500 copay per admission**	**No Charge**
Labor & Delivery Inpatient Professional Fee	**No Charge**	**No Charge**	**No Charge**
Other Services			
Skilled Nursing Facility Services (up to 100 days per benefit period)	**No Charge**	**No Charge**	**No Charge**
Ostomy and Urological Supplies; Prosthetic & Orthotic Devices	**No Charge**	**No Charge**	**No Charge**
Hospice Care	**No Charge**	**No Charge**	**No Charge**
Acupuncture & Chiropractic Services - Limits apply	**$10/30 visits combined w/chiro; Use ASH network**		
PRESCRIPTION DRUG PLANS			
Provider Network	**Sutter Health Plus**	**Sutter Health Plus**	**Kaiser Pharmacy**
Tier 1- Most Generic Drugs & Low-Cost Preferred Brand Name Rx	**Retail: $10 Copay/ 30 Days Mail: $20 Copay/ 100 Days**	**Retail: $10 Copay/ 30 Days Mail: $20 Copay/ 100 Days**	**Retail & Mail Order: $10 Copay/ 100 Days**
Tier 2- Preferred Brand Name Drugs, Non-Preferred Generics, & Drugs Recommended by SHP Pharmacy	**Retail: $30 Copay/ 30 Days Mail: $60 Copay/ 100 Days**	**Retail: $30 Copay/ 30 Days Mail: $60 Copay/ 100 Days**	**Retail & Mail Order: $30 Copay/ 100 Days**
Tier 3- Non-Preferred Brand Name Drugs or Drugs Recommended by SHP Pharmacy (Generally have a preferred & ofter less costly therapeutic alternative at a lower tier)	**Retail: $60 Copay/ 30 Days Mail: $120 Copay/ 100 Days**	**Retail: $60 Copay/ 30 Days Mail: $120 Copay/ 100 Days**	**N/A**
Tier 4- Drugs that are biologics or required to be distributed through a specialty pharmacy.	**Specialty Pharmacy: 20% coinsurance $100 per Rx for up to a 30-day supply**	**Specialty Pharmacy: 20% coinsurance $100 per Rx for up to a 30-day supply**	**Retail: $30 Copay/ 30 Days**

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. 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