



**SANTA CRUZ CITY SCHOOLS  
CERTIFICATED EMPLOYEE  
MONTHLY MEDICAL BENEFITS COST TABLE  
EFFECTIVE 10/01/2024 - 9/30/2025**

**CERTIFICATED MEDICAL PLANS**

	<b>SUTTER HEALTH PLUS HMO \$30-20% PLAN ID: SHPML82</b>	<b>SUTTER HEALTH PLUS HMO \$40-20% PLAN ID: SHPML83</b>	<b>KAISER HMO \$30-0 PLAN ID: HMOK</b>
Copays & Coinsurance			
Individual/Family Deductibles	\$0	\$0	\$0
Out of Pocket Maximum (Combined Medical and Rx)	\$2,000/\$4,000	\$3,000/\$6,000	\$1,500/\$3,000
Office Visit Co-Pay	\$30	\$40	\$30
Prescription Drug Plans	\$10/\$30 RX,	\$10/\$30 RX,	\$10/\$30 RX,
Network	Full Network	Full Network	KAISER ONLY

Monthly Premium	
SINGLE	\$939.60
2-PARTY	\$1,831.80
FAMILY	\$2,573.60

Monthly Premium	
SINGLE	\$909.00
2-PARTY	\$1,772.20
FAMILY	\$2,489.80

Monthly Premium	
SINGLE	\$939.93
2-PARTY	\$1,879.85
FAMILY	\$2,659.99

**FULL TIME EMPLOYEE (1.0 FTE)  
MONTHLY CONTRIBUTION**

Employer	Employee
\$604.99	\$334.61
\$1,176.45	\$655.35
\$1,651.62	\$921.98

Employer	Employee
\$605.18	\$303.82
\$1,177.69	\$594.51
\$1,654.23	\$835.57

Employer	Employee
\$539.58	\$400.35
\$1,074.54	\$805.31
\$1,523.26	\$1,136.73

**PART TIME EMPLOYEE (0.5-0.8300 FTE)  
MONTHLY CONTRIBUTION**

Employer	Employee
\$604.99	\$334.61
\$1,125.60	\$706.20
\$1,580.12	\$993.48

Employer	Employee
\$605.18	\$303.82
\$1,130.02	\$642.18
\$1,587.10	\$902.70



Employer	Employee
\$539.58	\$400.35
\$1,025.30	\$854.55
\$1,454.07	\$1,205.92

DISTRICT CONTRIBUTION	CERTIFICATED	Monthly Premium
	BENEFITS	
	DENTAL INCENTIVE PPO	\$121.40
	DELTA DENTAL UNLIMITED PPO	\$130.90
	CERTIFICATED - VSP	\$17.00
	LIFE INSURANCE	\$5.35

The employee's share costs are negotiated annually by your union and therefore are subject to change. SCCS will continue to pay 100% of premiums for Dental, Vision, and Life Insurance. Monthly employee premiums will be deducted from payroll checks in 10 equal installments starting in August. As the withdraw will be done in 10 installments, the monthly cost will be higher than the amount stated in the table.



**Santa Cruz City Schools Medical Plan Comparison**  
**Certificated & Management & Pre-Retirees**  
**Effective October 1, 2024- September 30, 2025**

 	SHP - Summit ML82HMO \$30-20%, Rx 10-30 Payroll ID: SHPML82	SHP - Summit ML83 HMO \$40-20%, Rx \$10-30 Payroll ID: SHPML83	Kaiser HMO \$30-0, Rx 10-30 Payroll ID: HMOKD
	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
<b>COPAY &amp; COINSURANCE</b>	\$30-20%	\$40-20%	\$30-0
Individual/Family Deductibles	\$0/\$0	\$0/\$0	\$0/\$0
Individual/Family Calendar Out-of-Pocket Max <i>(includes medical co-pays, deductibles and co-insurance)</i>	\$2,000/\$4,000	\$3,000/\$6,000	\$1,500/\$3,000
<b>Preventive Care Services (includes physical exams &amp; screenings)</b>			
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
<b>Outpatient Services</b>			
Office Visit - Primary Care Physician (PCP) for illness or injury	\$30	\$40	\$30
Sutter Walk-in Care visit	\$15	\$20	\$30
Telehealth Visit	\$15	\$20	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 administration	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-preventive 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
<b>Hospitalization Services</b>			
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
<b>Emergency &amp; Urgent Care Services</b>			
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
<b>Mental/ Behavioral Health &amp; Substance Use Disorder (MH/SUD)</b>			
MH/SUD Inpatient Facility Fee	\$500 copay per admission	\$500 copay per admission	No Charge
MH/SUD Telehealth Office Visits	\$15	\$20	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
<b>Home Health Services</b>			
Home Health Care (up to 100 visits per calendar year)	No Charge	No Charge	No Charge
<b>Maternity Care</b>			
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
<b>Other Services</b>			
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		
<b>PRESCRIPTION DRUG PLANS</b>			
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 & offer 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**