



**SANTA CRUZ CITY SCHOOLS
CLASSIFIED & CONFIDENTIAL
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2024 - 9/30/2025**

	HMO PLANS			PPO PLANS	
	BLUE SHIELD HMO \$25-500 #1H031001 PLAN ID: HMOBSH	BLUE SHIELD HMO \$25-500 TRIO #1H131001 PLAN ID: HMOPMG	KAISER HMO \$0-0 #605337-0006 PLAN ID: HMOBK	BLUE SHIELD PPO 90-E \$20 #0P031001 PLAN ID: PPOBSH	BLUE SHIELD PPO 80-K \$30 #0P051001 PLAN ID: PPOBSL
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	PAMF & Sutter Health EXCLUDED	KAISER ONLY	Full Network	Full Network

Monthly Premium		Monthly Premium		Monthly Premium		Monthly Premium		Monthly Premium	
SINGLE	\$1,254.00	SINGLE	\$1,147.00	SINGLE	\$1,089.00	SINGLE	\$1,445.00	SINGLE	\$1,258.00
2-PARTY	\$2,448.00	2-PARTY	\$2,234.00	2-PARTY	\$2,123.00	2-PARTY	\$2,834.00	2-PARTY	\$2,456.00
FAMILY	\$3,441.00	FAMILY	\$3,136.00	FAMILY	\$2,985.00	FAMILY	\$3,993.00	FAMILY	\$3,451.00

**FULL TIME EMPLOYEE (0.8750-1.0 FTE)
MONTHLY CONTRIBUTION**

	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	\$1,136.02	\$117.98	\$1,089.23	\$57.77	\$1,064.40	\$24.60	\$1,221.34	\$223.66	\$1,137.56	\$120.44
TWO PARTY (EMPLOYEE + ONE)	\$2,205.14	\$242.86	\$2,110.95	\$123.05	\$2,062.62	\$60.38	\$2,377.33	\$456.67	\$2,208.84	\$247.16
FAMILY (EMPLOYEE + TWO OR MORE)	\$3,089.71	\$351.29	\$2,954.90	\$181.10	\$2,886.84	\$98.16	\$3,334.51	\$658.49	\$3,092.95	\$358.05

**PART TIME EMPLOYEE (0.5-0.8125 FTE)
MONTHLY CONTRIBUTION**

	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	\$1,136.02	\$117.98	\$1,089.23	\$57.77	\$1,064.40	\$24.60	\$1,221.34	\$223.66	\$1,137.56	\$120.44
TWO PARTY (EMPLOYEE + ONE)	\$2,171.02	\$276.98	\$2,076.82	\$157.18	\$2,028.49	\$94.51	\$2,343.21	\$490.79	\$2,174.71	\$281.29
FAMILY (EMPLOYEE + TWO OR MORE)	\$2,995.52	\$445.48	\$2,860.71	\$275.29	\$2,792.65	\$192.35	\$3,240.32	\$752.68	\$2,998.76	\$452.24

CLASSIFIED BENEFITS	Monthly Premium
DENTAL INCENTIVE PPO	\$110.00
DELTA DENTAL UNLIMITED PPO	\$117.00
CLASSIFIED & CONFIDENTIAL - VSP	\$15.80
LONG-TERM DISABILITY	\$17.12
LIFE INSURANCE	\$5.35

CONFIDENTIAL BENEFITS	Monthly Premium
DENTAL INCENTIVE PPO	\$110.00
DELTA DENTAL UNLIMITED PPO	\$117.00
CLASSIFIED & CONFIDENTIAL - VSP	\$15.80
LONG-TERM DISABILITY	\$17.12
LIFE INSURANCE	\$21.42

****The employee's share costs are negotiated annually by your union and therefore rates shown above are subject to change.****
Your cost for medical premiums will be deducted from your payroll check in 10 equal installments starting in August. As the withdraw will be done in 10 installments, the monthly cost will be higher than the



**Santa Cruz City Schools - Classified & Confidential - SISC Medical Plan Comparison Effective
OCTOBER 1, 2024 - SEPTEMBER 30, 2025**

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) \$25-500, Rx 5-20 PLAN ID: HMOBSH	Blue Shield TRIO HMO \$25-500, Rx 5-20 PLAN ID: HMOPMG	Kaiser HMO \$0 CO PAY, Rx 5-5 PLAN ID: HMOK	Blue Shield PPO 90-E \$20, Rx 7-25 PLAN ID: PPOBSH	Blue Shield PPO 80-K \$30, Rx 5-20 PLAN ID: PPOBSL
GROUP NUMBER	1H031001	1H081001	606394-0079ALN	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/ Urgent Care co-pay	\$25	\$25	\$0	\$20	\$30
Specialists/Consultants co-pay	\$25	\$25	\$0	\$20	\$30
Prenatal, postnatal office visit co-pay	\$0	\$0	\$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	\$100 co-pay +10%	\$100 co-pay +20%
Inpatient Hospital co-pay (preauthorization required)	\$500	\$500	\$0	10%	20%
Outpatient Hospital co-pay	\$500	\$500	\$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					
INPATIENT CARE: Facility based care (preauthorization required)	\$500	\$500	\$0	10%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	\$25	\$25	\$0	Deductible waived; OV co-pay applies	Deductible waived; OV co-pay applies

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%	20%
Ambulance (Ground or Air)	\$100	\$100	\$50	\$100 co-pay + 10%	\$100 co-pay + 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%
Hearing Aids	50% benefit allowance per 24 months device per 24 months in excess allowance Cost	50% benefit allowance per 24 months device per 24 months in excess allowance Cost		\$700 benefit allowance per 24 month period Cost in excess allowance	\$700 benefit allowance per 24 month period Cost in excess allowance
Physical and Occupational Therapy - Limits apply	\$25	\$25	\$0	10%	20%

PRESCRIPTION DRUG PLANS

Provider Network	Navitus	Navitus	Kaiser	Navitus	Navitus
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 - \$5 / 100-day	\$0 - \$60 / 90-day	\$0 - \$90 / 90-day
Prescription Drug Out-of-Pocket Maximum	\$1,500 / \$2,500	\$1,500 / \$2,500	\$2,500 / \$3,500	\$1,500 / \$2,500	\$1,500 / \$2,500

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.