SANTA CRUZ CITY SCHOOLS
CERTIFICATED EMPLOYEE
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2020 - 9/30/2021

CERTIFICATED EMPLOYEES	HMO PLANS				PPO PLANS		
	BLUE SHIELD HMO-$30-20%	**BLUE SHIELD *HMO-$30-20% TRIO**	**BLUE SHIELD HMO-$40-40%**	**KAISER HMO-$30-0**	**BLUE SHIELD PPO-80-M $40**	**BLUE SHIELD PPO-HSA-PLAN B**	**BLUE SHIELD PPO-MINIMUM VALUE**
	#1H011000 **Payroll ID: HMOBSH**	#1H111000 **Payroll ID: HMOPMG**	#1H051000 **Payroll ID: HMOBSL**	605337-0004 **Payroll ID: HMOK**	#0P011000 **Payroll ID: PPOBSH**	#0P021000 **Payroll ID: PPOBSL**	#0P041003 **Payroll ID: PPOBSMV**
Individual/Family Deductibles	N/A	N/A	N/A	N/A	$3,000/$6,000	$3,000/$5,200	$5,000/$10,000
Out of Pocket Maximum	$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
	20% Deductible	20% Deductible	40% Deductible				
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 (Out of Pocket Maximum)	$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
	Monthly Premium	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**	**Monthly Premium**
	SINGLE $924.00	**SINGLE $845.00**	**SINGLE $837.00**	**SINGLE $803.00**	**SINGLE $799.00**	**SINGLE $855.00**	**SINGLE $754.00**
	2-PARTY $1,801.00	**2-PARTY $1,644.00**	**2-PARTY $1,633.00**	**2-PARTY $1,563.00**	**2-PARTY $1,550.00**	**2-PARTY $1,697.00**	**2-PARTY $1,495.00**
	FAMILY $2,530.00	**FAMILY $2,306.00**	**FAMILY $2,295.00**	**FAMILY $2,196.00**	**FAMILY $2,173.00**	**FAMILY $2,414.00**	**FAMILY $2,126.00**
FULL TIME EMPLOYEE (0.90-1.0 FTE) MONTHLY CONTRIBUTION	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**
SINGLE (EMPLOYEE ONLY)	$498.40 / $425.60	$447.90 / $397.10	$447.30 / $389.70	$418.50 / $384.50	$420.50 / $378.50	$458.30 / $396.70	$405.80 / $348.20
TWO PARTY (EMPLOYEE + ONE	$970.10 / $830.90	$869.40 / $774.60	$870.70 / $762.30	$812.70 / $750.30	$826.60 / $723.40	$923.30 / $773.70	$816.30 / $678.70
FAMILY (EMPLOYEE + TWO OR MORE)	$1,362.40 / $1,167.60	$1,218.80 / $1,087.20	$1,222.90 / $1,072.10	$1,141.80 / $1,054.20	$1,139.50 / $1,033.50	$1,290.20 / $1,123.80	$1,140.60 / $985.40
PART TIME EMPLOYEE (0.5-0.8 FTE) MONTHLY CONTRIBUTION	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**	**Employer / Employee**
SINGLE (EMPLOYEE ONLY)	$498.40 / $425.60	$447.90 / $397.10	$447.30 / $389.70	$418.50 / $384.50	$420.50 / $378.50	$458.30 / $396.70	$405.80 / $348.20
TWO PARTY (EMPLOYEE + ONE	$919.25 / $881.75	$820.16 / $823.84	$823.03 / $809.97	$763.46 / $799.54	$781.38 / $768.62	$877.00 / $820.00	$776.02 / $718.98
FAMILY (EMPLOYEE + TWO OR MORE)	$1,290.90 / $1,239.10	$1,149.61 / $1,156.39	$1,155.77 / $1,139.23	$1,072.61 / $1,123.39	$1,072.72 / $1,100.28	$1,220.27 / $1,193.73	$1,079.77 / $1,046.23

CERTIFICATED BENEFITS	Monthly Premium
DENTAL INCENTIVE PPO	$116.00
DELTA DENTAL UNLIMITED PPO	$125.00
CERTIFICATED - VSP	$19.70
LIFE INSURANCE	$4.46
MONTHLY DISTRICT CONTRIBUTION	**$265.16**

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

**Monthly contributions will be deducted from your payroll check in 10 equal installments starting in October. As the withdraw will be done in 10 installments, the monthly cost will be higher than the amount stated in the table.

SISC
Self-Insured Schools of California
Schools Helping Schools

Santa Cruz City Schools - Certificated - SISC Medical Plan Comparison - Effective October 1, 2020

SISC PLAN NAME	Blue Shield HMO-Full (includes PAMF) 30-20%, Rx 9-35 Payroll ID: HMOBSH	Blue Shield TRIO HMO 30-20%, Rx 9-35 Payroll ID: HMOPMG	Blue Shield HMO-Full (includes PAMF) 40-40%, Rx $200/10-35 Payroll ID: HMOBSL	Kaiser HMO $30-0, Rx 10-30 Payroll ID: HMOK	Blue Shield PPO** 80-M $40, Rx 9-35 Payroll ID: PPOBSH	Blue Shield PPO** HDHP - HSA- Plan B Payroll ID: PPOBSL	Blue Shield PPO** Minimum Value Plan Payroll ID: PPOBSMV	Blue Shield PPO ** WABE (Single Only) Payroll ID: WABEB
GROUP NUMBER	**1H011000** $30-20%	**1H111000** $30-20%	**H051000** $40-40%	**605337-0004** $30-0	**0P011000** 80-M $40	**0P021000** HSA-Plan B	**0P041003** MINIMUM VALUE (Dental & Vision Included)	**WABE69815B** ANCHOR BRONZE (Dental & Vision Included)
	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/$5,200**	**$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**
PROFESSIONAL SERVICES								
Office Visit co-pay	**$30**	**$30**	**$40**	**$30**	**$40**	10%	30% After deductible is met	30% After deductible is met
Urgent Care co-pay	**$30**	**$30**	**$40**	**$30**	**$40**	10%	30% After deductible is met	30% After deductible is met
Specialists/Consultants co-pay	**$45**	**$45**	**$50**	**$30**	**$40**	10%	30% After deductible is met	30% After deductible is met
Prenatal, postnatal office visit co-pay	**$30**	**$30**	**$0**	**$0**	**$40**	10%	30% After deductible is met	30% After deductible is met
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%	Office visit co-pay or hospitalization co-pay applies	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
HOSPITAL & SKILLED NURSING FACILITY SERVICES								
Emergency Room visit co-pay (waived if admitted)	$150	$150	$200	$100	$100 co-pay + 20%	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	$0	$0	$40	$30	20%	10%	30%	30%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$0	$0	40%	$30	20%	10%	30%	30%
Surgery, Outpatient (performed in a Hospital)	$0	$0	$0	$30	20%	10%	30%	30%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT								
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%
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	$10/30 visits	20%	10%	30%	30%
Ambulance (Ground or Air)	$100	$100	$100	$50	$100 co-pay + 20%	$100 co-pay + 10%	30% after $100 co-pay	30% after $100 co-pay
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	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%
PRESCRIPTION DRUG PLANS								
Provider Network	**Navitus**	**Navitus**	**Navitus**	**Kaiser**	**Navitus**	**Blue Shield**	**Blue Shield**	**Blue Shield**
Generic co-pay/days supply	$9 / 30-day	$9 / 30-day	$10 / 30-day	$10 /100-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 /100-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 Ded. Applies
Mail Order (Generic-Brand co-pay/days supply)	$0 - $90 / 90-day	$0 - $90 / 90-day	$0 - $90 / 90-day	$10-30 /100-day	$0 - $90 / 90-day	After medical deductible, $0-90/90-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. **For PPO plans, deductibles must be met before certain services are covered see Summary of Benefits for more information. 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.