



**SANTA CRUZ CITY SCHOOLS
CABINET & MANAGEMENT
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2025 - 9/30/2026**

| | MEDICAL PLANS | | | HIGH DEDUCTIBLE HEALTH PLANS | | |
|---|--|--|--|--|--|--|
| | SUTTER HEALTH HMO \$30/20% | SUTTER HEALTH HMO \$40/20% | KAISER HMO \$30/0 | SUTTER HEALTH VISTA HDHP \$30/20% | KAISER KAISER HDHP \$30/30% | |
| Copays & Coinsurance | \$30/20% | \$40/20% | \$30/0 | \$30/20% | \$30/30% | |
| Individual/Family Deductibles | \$0 | \$0 | \$0 | \$4,000/\$8,000 | \$3,500/\$7,000 | |
| Out of Pocket Maximum (Combined Medical and Rx) | \$2,000/\$4,000 | \$3,000/\$6,000 | \$1,500/\$3,000 | \$6,500/\$13,000 | \$6,000/\$12,000 | |
| Office Visit Co-Pay | \$30 | \$40 | \$30 | \$30 After Deductible | \$30 After Deductible | |
| Prescription Drug Plans | \$10/\$30 RX, | \$10/\$30 RX, | \$10/\$30 RX, | \$30/\$60 Rx After Deductible | \$15/\$35 Rx After Deductible | |
| Network | Sutter Health HMO | Sutter Health HMO | KAISER ONLY | Sutter Health HMO | KAISER ONLY | |
| | Monthly Premium | Monthly Premium | Monthly Premium | Monthly Premium | Monthly Premium | |
| | SINGLE \$1,121.70 2-PARTY \$2,186.70 FAMILY \$3,072.20 | SINGLE \$1,085.10 2-PARTY \$2,115.50 FAMILY \$2,972.00 | SINGLE \$1,027.43 2-PARTY \$2,054.86 FAMILY \$2,907.62 | SINGLE \$754.80 2-PARTY \$1,471.20 FAMILY \$2,066.60 | SINGLE \$625.64 2-PARTY \$1,251.28 FAMILY \$1,770.56 | |
| FULL TIME EMPLOYEE (1.0 FTE) MONTHLY CONTRIBUTION | Employer Employee | Employer Employee | Employer Employee | Employer Employee | Employer Employee | |
| SINGLE (EMPLOYEE ONLY) | \$759.77 \$361.93 | \$754.86 \$330.24 | \$613.95 \$413.48 | \$513.26 \$241.54 | \$425.44 \$200.20 | |
| TWO PARTY (EMPLOYEE + ONE) | \$1,478.11 \$708.59 | \$1,469.49 \$646.01 | \$1,223.30 \$831.56 | \$1,000.42 \$470.78 | \$850.87 \$400.41 | |
| FAMILY (EMPLOYEE + TWO OR MORE) | \$2,075.43 \$996.77 | \$2,064.10 \$907.90 | \$1,733.74 \$1,173.88 | \$1,405.29 \$661.31 | \$1,203.98 \$566.58 | |
| PART TIME EMPLOYEE (0.5-0.8300 FTE) MONTHLY CONTRIBUTION | Employer Employee | Employer Employee | Employer Employee | Employer Employee | Employer Employee | |
| SINGLE (EMPLOYEE ONLY) | \$759.77 \$361.93 | \$754.86 \$330.24 | \$613.95 \$413.48 | \$513.26 \$241.54 | \$425.44 \$200.20 | |
| TWO PARTY (EMPLOYEE + ONE) | \$1,427.26 \$759.44 | \$1,421.82 \$693.68 | \$1,174.06 \$880.80 | \$956.28 \$514.92 | \$813.33 \$437.95 | |
| FAMILY (EMPLOYEE + TWO OR MORE) | \$2,003.93 \$1,068.27 | \$1,996.97 \$975.03 | \$1,664.55 \$1,243.07 | \$1,343.29 \$723.31 | \$1,150.86 \$619.70 | |
| DISTRICT CONTRIBUTIONS | DISTRICT CONTRIBUTIONS | | DISTRICT CONTRIBUTIONS | | DISTRICT CONTRIBUTIONS | |
| CERTIFICATED MGMT & CABINET | Monthly Premium | | CLASSIFIED MGMT & CABINET | | Monthly | |
| DENTAL INCENTIVE PPO | \$121.40 | | DENTAL INCENTIVE PPO | | \$121.40 | |
| DELTA DENTAL UNLIMITED PPO | \$130.90 | | DELTA DENTAL UNLIMITED PPO | | \$130.90 | |
| MANAGEMENT - VSP | \$17.00 | | MANAGEMENT - VSP | | \$17.00 | |
| LIFE INSURANCE | \$21.42 | | LIFE INSURANCE | | \$21.42 | |
| | | | LONG TERM DISABILITY | | \$59.76 | |

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

*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, 2025 - September 30, 2026**

| | Sutter Health Plan | Sutter Health Plan | Kaiser | Sutter Health Plan | Kaiser |
|--|--|--|---|---|--|
| | HMO \$30 | HMO \$40 | HMO \$30 | High Deductible Health Plan | High Deductible Health Plan |
| | Member Pays | Member Pays | Member Pays | Member Pays | Member Pays |
| COPAY & COINSURANCE | \$30/20% | \$40/20% | \$30/0 | \$30/20% | \$30/30% |
| | \$0/\$0 | \$0/\$0 | \$0/\$0 | \$4,000/\$8,000 | \$3,500/\$7,000 |
| 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 | \$6,500/\$13,000 | \$6,000/\$12,000 |
| Preventive Care Services (includes physical exams & screenings) | | | | | |
| Annual Eye Exam for Refraction | No Charge | No Charge | No Charge | No Charge | No Charge |
| Family Planning Counseling & Services (Preconception Care Visits) | No Charge | No Charge | No Charge | No Charge | No Charge |
| Routine preventive immunizations/vaccines | No Charge | No Charge | No Charge | No Charge | No Charge |
| Routine Preventive Medical Exams, Procedures & Screenings | No Charge | No Charge | No Charge | No Charge | No Charge |
| Routine Preventive Imaging and Lab Services | No Charge | No Charge | No Charge | No Charge | \$10 per procedure |
| Preventive Care Rx, Supplies, Equipment & Supplements | No Charge | No Charge | No Charge | No Charge | No Charge |
| Outpatient Services | | | | | |
| Office Visit - Primary Care Physician (PCP) for illness or injury | \$30 | \$40 | \$30 | \$40 copay after deductible | \$30 copay after deductible |
| Sutter Walk-In Care office/video visit, where available | \$15 | \$20 | \$30 | \$20 copay after deductible | No Charge after deductible |
| Specialist Office Visit | \$30 | \$40 | \$30 | \$40 copay after deductible | \$50 copay after deductible |
| Allergy Services (includes testing, injections, and serum) | \$30 | \$40 | No Charge | \$40 copay after deductible | |
| Medically administered drugs dispensed by a PCP for administration | No Charge | No Charge | No Charge | No charge after deductible | No Charge after deductible |
| Outpatient Rehabilitation Services | \$30 | \$40 | \$30 | \$40 copay after deductible | \$30 per visit after deductible |
| Outpatient Habilitation Services | Not Covered | Not Covered | \$30 | Not Covered | \$30 per visit after deductible |
| Outpatient Surgery Facility Fee | \$100 Copay per visit | \$100 Copay per visit | \$30 per procedure | \$40 copay after deductible | 30% coinsurance after deductible |
| Outpatient Surgery Professional Fee | No Charge | No Charge | No Charge | No charge after deductible | 30% coinsurance after deductible |
| Outpatient Visit (non-office visit) | \$60 | \$80 | N/A | \$40 copay after deductible | \$30 copay after deductible |
| Non-preventive Lab Services | \$10 | \$10 | No Charge | \$40 copay after deductible | \$10 copay after deductible |
| Radiological & Nuclear Imaging (MRI, CT, and PET Scans) | \$50 | \$50 | No Charge for most Scans | \$50 copay per procedure after deductible | 30% coinsurance after deductible |
| Diagnostic & Therapeutic Imaging & Testing (x-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test & cardiac monitoring) | \$10 | \$10 | No Charge for most Testing | \$15 copay per procedure after deductible | \$10 copay per procedure after deductible |
| Hospitalization Services | | | | | |
| Inpatient Facility Fee (hospital room, medical supplies, & inpatient drugs including anesthesia) | \$500 | \$500 | No Charge | \$500 copay per admission after deductible | 30% coinsurance after deductible |
| Inpatient Professional Fees (surgeon and anesthesiologist) | No Charge | No Charge | No Charge | No charge after deductible | No Charge |
| Emergency & Urgent Care Services | | | | | |
| Emergency Room Facility Fee | \$150 | \$150 | \$100 | \$150 copay after deductible | 30% coinsurance after deductible |
| Emergency room Professional fee | No Charge | No Charge | No Charge | No charge after deductible | N/A |
| Urgent Care - consultations, exams, and treatments | \$40 | \$40 | \$30 | \$40 copay after deductible | \$30 copay after deductible |
| Ambulance Services - Medical Transportation | | | | | |
| | \$100/ per trip | \$150/ per trip | \$50/ per trip | \$150 copay per trip after deductible | 30% coinsurance after deductible |
| Durable Medical Equipment, Prosthetics, Orthotics and Supplies | | | | | |
| Durable medical equipment for home use | 20% Coinsurance | 20% Coinsurance | No Charge | 20% coinsurance after deductible | 30% coinsurance after deductible |
| Ostomy and urological supplies; prosthetic and orthotic devices | No Charge | No Charge | No Charge | No charge after deductible | No Charge after deductible |
| Mental/ Behavioral Health & Substance Use Disorder (MH/SUD) | | | | | |
| MH/SUD Inpatient Facility Fee | \$500 copay per admission | \$500 copay per admission | No Charge | \$500 copay per admission after deductible | 30% coinsurance after deductible |
| MH/SUD Inpatient Professional fees (see Endnotes) | No Charge | No Charge | No Charge | No charge after deductible | N/A |
| MH/SUD Telehealth/ Group outpatient Visits | \$15 | \$20 | \$5 | \$20 copay after deductible | \$15 Copay after deductible |
| MH/SUD Individual outpatient Office Visits | \$30 | \$40 | \$30 | \$40 copay after deductible | \$30 copay after deductible |
| MH/SUD Other Outpatient Services | \$60 | \$80 | N/A | \$40 copay after deductible | 30% coinsurance after deductible |
| Children and Youth Behavioral Health Initiative (CYBHI) school site behavioral health services | No Charge | No Charge | \$30 | No charge after deductible | \$30 copay after deductible |
| Maternity Care | | | | | |
| Routine Prenatal Care Visits & First Postnatal Visits | No Charge | No Charge | No Charge | No Charge | No Charge |
| Breastfeeding Counseling Services & Supplies | No Charge | No Charge | No Charge | No Charge | No Charge |
| Labor & Delivery Inpatient Facility Fee | \$500 copay per admission | \$500 copay per admission | No Charge | \$500 copay per admission after deductible | 30% coinsurance after deductible |
| Labor & Delivery Inpatient Professional Fee | No Charge | No Charge | No Charge | No charge after deductible | 30% coinsurance after deductible |
| Abortion Services | | | | | |
| Abortion (e.g., medication or procedural abortions) | No Charge | No Charge | No Charge | No charge after deductible | No charge after deductible |
| Abortion-related services, including pre-abortion and follow-up services | No Charge | No Charge | No Charge | No charge after deductible | No charge after deductible |
| Other Services for Special Health Needs | | | | | |
| Skilled Nursing Facility Services (up to 100 days per benefit period) | No Charge | No Charge | No Charge | \$250 copay per admission after deductible | 30% coinsurance after deductible |
| Home Health Care (up to 100 visits per calendar year) | No Charge | No Charge | No Charge | No charge after deductible | No charge after deductible |
| Hospice Care | No Charge | No Charge | No Charge | No charge after deductible | No Charge |
| Infertility and fertility services as described in the EOC (see Endnotes) | See applicable category of Covered Services | See applicable category of Covered Services | See applicable category of Covered Services | See applicable category of Covered Services | See applicable category of Covered Services |
| Acupuncture & Chiropractic Services - Limits apply | | | | | |
| | \$10/30 visits combined w/chiro; Use ASH network | | | Not Covered | Not Covered |
| PRESCRIPTION DRUG PLANS | | | | | |
| Provider Network | Sutter Health Plan | Sutter Health Plan | Kaiser Pharmacy | Sutter Health Plan | 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 | Retail-30: \$10 copay per Rx after deductible Retail-90/Mail order: \$20 copay per Rx after deductible 100-day supply | Retail & Mail Order:\$15 Copay/ 30-day after deductible \$30 copay/ 100-day after deductible |
| 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 | Retail-30: \$30 copay per Rx after deductible Retail-90/Mail order: \$60 copay per Rx after deductible 100-day | Retail & Mail Order:\$35 Copay/ 30-day after deductible \$70 copay/ 100-day after deductible |
| 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 | Retail-30: \$60 copay per Rx after deductible Retail-90/Mail order: \$120 copay per Rx after deductible 100-day | 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 | Specialty Pharmacy: 20% coinsurance up to \$250 per prescription after deductible for up to a 30-day supply | 30% coinsurance (not to exceed \$250) for up to 30-day supply after deductible |

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