SANTA CRUZ CITY SCHOOLS
CERTIFICATED EMPLOYEE
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE 10/01/2026 - 9/30/2027

	HMO MEDICAL PLANS			HIGH DEDUCTIBLE HEALTH PLANS	
	SUTTER HEALTH HMO	SUTTER HEALTH HMO	KAISER HMO	SUTTER HEALTH VISTA HDHP	KAISER KAISER HDHP
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)	$2,500/$5,000	$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
Member Services Contact	(855) 315-5800	(855) 315-5800	(800) 464-4000	(855) 315-5800	(855) 315-5800
Monthly Premium					
SINGLE	$1,375.20	$1,330.40	$1,110.62	$926.00	$683.14
2-PARTY	$2,680.60	$2,593.20	$2,221.24	$1,804.80	$1,366.28
FAMILY	$3,766.00	$3,643.30	$3,143.06	$2,535.40	$1,933.29

FULL TIME EMPLOYEE (0.9-1.0 FTE) MONTHLY CONTRIBUTION

	Pay Cycle	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	12-Month	$937.22	$437.98	$926.57	$403.83	$672.18	$438.44	$633.10	$292.90	$465.69	$217.45
	9,10,11 Month	$1,124.66	$525.58	$1,111.88	$484.60	$806.62	$526.13	$759.72	$351.48	$558.83	$260.94
TWO PARTY (EMPLOYEE + ONE)	12-Month	$1,823.84	$856.76	$1,803.88	$789.32	$1,339.77	$881.47	$1,233.94	$570.86	$931.37	$434.91
	9,10,11 Month	$2,188.61	$1,028.11	$2,164.66	$947.18	$1,607.72	$1,057.76	$1,480.73	$685.03	$1,117.64	$521.89
FAMILY (EMPLOYEE + TWO OR MORE)	12-Month	$2,561.09	$1,204.91	$2,534.01	$1,109.29	$1,898.55	$1,244.51	$1,733.45	$801.95	$1,317.89	$615.40
	9,10,11 Month	$3,073.31	$1,445.89	$3,040.81	$1,331.15	$2,278.26	$1,493.41	$2,080.14	$962.34	$1,581.47	$738.48

PART TIME EMPLOYEE (0.5-0.8300 FTE) MONTHLY CONTRIBUTION

	Pay Cycle	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee	Employer	Employee
SINGLE (EMPLOYEE ONLY)	12-Month	$937.22	$437.98	$926.57	$403.83	$672.18	$438.44	$633.10	$292.90	$465.69	$217.45
	9,10,11 Month	$1,124.66	$525.58	$1,111.88	$484.60	$806.62	$526.13	$759.72	$351.48	$558.83	$260.94
TWO PARTY (EMPLOYEE + ONE)	12-Month	$1,773.00	$907.60	$1,756.21	$836.99	$1,290.53	$930.71	$1,189.80	$615.00	$893.83	$472.45
	9,10,11 Month	$2,127.60	$1,089.12	$2,107.45	$1,004.39	$1,548.64	$1,116.85	$1,427.76	$738.00	$1,072.60	$566.94
FAMILY (EMPLOYEE + TWO OR MORE)	12-Month	$2,489.59	$1,276.41	$2,466.88	$1,176.42	$1,829.36	$1,313.70	$1,671.45	$863.95	$1,264.77	$668.52
	9,10,11 Month	$2,987.51	$1,531.69	$2,960.26	$1,411.70	$2,195.23	$1,576.44	$2,005.74	$1,036.74	$1,517.72	$802.22

SCCS will pay 100% of the monthly premiums for Dental, Vision and Group Life Insurance for the 2026-2027 Plan Year.

CERTIFICATED BENEFITS	Monthly Premium
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 GSCFT and therefore are subject to change. SCCS will conntinue 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 & Managmement
Effective October 1, 2026 - September 30, 2027

	Sutter Health Plan HMO $30	Sutter Health Plan HMO $40	Kaiser HMO $30	Sutter Health Plan High Deductible Health Plan	Kaiser High Deductible Health Plan
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
COPAY & COINSURANCE	$30/20%	$40/20%	$30/0	$40/20%	$30/30%
	$0/$0	**$0/$0**	**$0/$0**	**$4,000/$8,000**	**$3,500/$7,000**
Individual/Family Calendar Out-of-Pocket Max (includes medical co-pays, deductibles and co-insurance)	**$2,500/$5,000**	**$3,000/$6,000**	**$1,500/$3,000**	**$6,500/$13,000**	**$6,000/$12,0000**
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 / Video Visit	$60 / $30 (Telehealth)	$80 / $40 (Telehealth)	$30	$80 / $40 (Video) copay after deductible	$50 copay after deductible
Allergy Services (includes testing, injections, and serum)	$60	$80	No Charge	$80 copay after deductible	
Medically administered drugs dispensed by a PCP for adminsitration	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	$250 copay per admission 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	$250 copay after deductible	$30 copay after deductible
Non-prevenitive 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)	$250	$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	$200	$200	$100	$300 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	$60	$80	$30	$80 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	50% Coinsurance	50% Coinsurance	No Charge	50% coinsurance after deductible	30% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	50% Coinsurance	50% Coinsurance	No Charge	50% coinsurance after deductible	No Charge after deductible
Mental/ Behavioral Health & Substance Use Disorder (MH/SUD)					
MH/SUD Inpatient Facility Fee	$250 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	$15 / $5 Substance Abuse Treatment	$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	$250 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	$250 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)	$125 Copay per day up to 5 day max per admission	$250 Copay per day up to 5 day max per admission	No Charge	$250 copay per day up to a max of 5 days 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 & ofter less costly therapeutic alternative at a lower tier)	Retail: $75 Copay/ 30 Days Mail: $150 Copay/ 100 Days	Retail: $75 Copay/ 30 Days Mail: $150 Copay/ 100 Days	N/A	Retail-30: $75 copay per Rx after deductible Retail-90/Mail order : $150 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 $250 per Rx for up to a 30-day supply	Specialty Pharmacy: 20% coinsurance $250 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