SANTA CRUZ CITY SCHOOLS - CLASSIFIED & CONFIDENTIAL
MONTHLY MEDICAL BENEFITS COST TABLE
EFFECTIVE OCTOBER 1, 2026 - SEPTEMBER 30, 2027

	HMO PLANS			PPO PLANS		
	BLUE SHIELD HMO $25-500 698151H031001	**BLUE SHIELD HMO $25-500 TRIO** 698151H131001	**KAISER HMO $0-0** 606394-0079 ALN	**BLUE SHIELD PPO 90-E $20** 698150P031001	**BLUE SHIELD PPO 80-K $30** 698150P051001	**ANTHEM GOLD SISC PROACTIVE PLAN $0-0** M471
Individual/Family Deductibles	N/A	N/A	N/A	$300/$600	$1,000/$2,000	$0/$0
Out of Pocket Maximum	$2,000/$4,000	$2,000/$4,000	$1,500/$3,000	$1,000/$3,000	$3,000/$6,000	$3,000/$6,000
Office Visit Co-Pay	$25	$25	$0	$20	$30	$0
Prescription Drug Plans (Out of Pocket Maximum)	$5/$20 RX $1,500/$2,500	$5/$20 RX $1,500/$2,500	$5/$5 RX Included w/ Medical Out of Pocket Max	$7/$25 RX $1,500/$2,500	$5/$20 RX $1,500/$2,500	$9/35 RX $2,500/$3,500
Network	Full Network	PAMF & Sutter Health EXCLUDED	KAISER ONLY	Full Network	Full Network	Full Network
Member Services Contact	(800) 855-599-2650	(800) 855-599-2650	(800) 464-4000	(800) 855-599-2650	(800) 855-599-2650	(866) 259-5540
Monthly Premium						
SINGLE	$1,550.00	$1,416.00	$1,345.00	$1,804.00	$1,555.00	$1,526.00
2-PARTY	$3,031.00	$2,764.00	$2,625.00	$3,544.00	$3,040.00	$2,990.00
FAMILY	$4,263.00	$3,883.00	$3,692.00	$4,996.00	$4,277.00	$4,213.00
FULL TIME EMPLOYEE (0.8750-1.0 FTE) MONTHLY CONTRIBUTION						
SINGLE (EMPLOYEE ONLY)	12-Month: $1,417.15 / $132.85	12-Month: $1,354.85 / $61.15	12-Month: $1,325.38 / $19.62	12-Month: $1,557.77 / $246.23	12-Month: $1,428.94 / $126.06	12-Month: $1,408.94 / $117.06
	9,10,11 Month: $1,700.58 / $159.42	9,10,11 Month: $1,625.82 / $73.38	9,10,11 Month: $1,590.46 / $23.54	9,10,11 Month: $1,869.32 / $295.48	9,10,11 Month: $1,714.73 / $151.27	9,10,11 Month: $1,690.73 / $140.47
TWO PARTY (EMPLOYEE + ONE)	12-Month: $2,759.44 / $271.56	12-Month: $2,634.58 / $129.42	12-Month: $2,575.02 / $49.98	12-Month: $3,042.88 / $501.12	12-Month: $2,782.22 / $257.78	12-Month: $2,761.38 / $228.62
	9,10,11 Month: $3,311.33 / $325.87	9,10,11 Month: $3,161.50 / $155.30	9,10,11 Month: $3,090.02 / $59.98	9,10,11 Month: $3,651.46 / $601.34	9,10,11 Month: $3,338.66 / $309.34	9,10,11 Month: $3,313.66 / $274.34
FAMILY (EMPLOYEE + TWO OR MORE)	12-Month: $3,874.26 / $388.74	12-Month: $3,696.03 / $186.97	12-Month: $3,611.69 / $80.31	12-Month: $4,277.66 / $718.34	12-Month: $3,906.95 / $370.05	12-Month: $3,976.39 / $318.93
	9,10,11 Month: $4,649.11 / $466.49	9,10,11 Month: $4,435.24 / $224.36	9,10,11 Month: $4,334.03 / $96.37	9,10,11 Month: $5,133.19 / $862.01	9,10,11 Month: $4,688.34 / $444.06	9,10,11 Month: $4,771.66 / $382.72
PART TIME EMPLOYEE (0.5-0.8125 FTE) MONTHLY CONTRIBUTION						
SINGLE (EMPLOYEE ONLY)	12-Month: $1,417.15 / $132.85	12-Month: $1,354.85 / $61.15	12-Month: $1,325.38 / $19.62	12-Month: $1,557.77 / $246.23	12-Month: $1,428.94 / $126.06	12-Month: $1,408.94 / $117.06
	9,10,11 Month: $1,700.58 / $159.42	9,10,11 Month: $1,625.82 / $73.38	9,10,11 Month: $1,590.46 / $23.54	9,10,11 Month: $1,869.32 / $295.48	9,10,11 Month: $1,714.73 / $151.27	9,10,11 Month: $1,690.73 / $140.47
TWO PARTY (EMPLOYEE + ONE)	12-Month: $2,725.32 / $305.68	12-Month: $2,610.45 / $153.55	12-Month: $2,540.89 / $84.11	12-Month: $3,008.76 / $535.24	12-Month: $2,748.09 / $291.91	12-Month: $2,708.88 / $281.12
	9,10,11 Month: $3,270.38 / $366.82	9,10,11 Month: $3,132.54 / $184.26	9,10,11 Month: $3,049.07 / $100.93	9,10,11 Month: $3,610.51 / $642.29	9,10,11 Month: $3,297.71 / $350.29	9,10,11 Month: $3,250.66 / $337.34
FAMILY (EMPLOYEE + TWO OR MORE)	12-Month: $3,780.07 / $482.93	12-Month: $3,601.84 / $281.16	12-Month: $3,517.50 / $174.50	12-Month: $4,183.47 / $812.53	12-Month: $3,812.76 / $464.24	12-Month: $3,820.13 / $392.87
	9,10,11 Month: $4,536.08 / $579.52	9,10,11 Month: $4,322.21 / $337.39	9,10,11 Month: $4,221.00 / $209.40	9,10,11 Month: $5,020.16 / $975.04	9,10,11 Month: $4,575.31 / $557.09	9,10,11 Month: $4,584.16 / $471.44

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

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 SCCCE and therefore rates shown above are subject to change.****

The cost for medical premiums will be deducted from your payroll check in 10 equal installments beginning in August. If you are on a 9, 10, or 11 monthly pay cycle, the monthly cost will be the amount listed in the 9,10,11 month row of the table.

SISC
Self-Insured Schools of California
Schools Helping Schools

Santa Cruz City Schools - Classified & Confidential Medical Plan Comparison

Effective October 1, 2026 - September 30, 2027

SISC Plan Name	Blue Shield Access+ HMO Full-Network $25-500, Rx 5-20	Blue Shield TRIO HMO Excludes PAMF $25-500, Rx 5-20	Kaiser HMO $0 CO PAY, Rx 5-5	Blue Shield PPO 90-E $20, Rx 7-25	Blue Shield PPO 80-K $30, Rx 5-20	Anthem Gold SISC Proactive PPO
	25-500	25-500	$0 OV, $5 Rx (Non-Marketed)	90-E $20 (Non-Marketed)	80-K $30	Gold
GROUP NUMBER	698151H031001	698151H131001	606394-0079ALN	698150P031001	698150P051001	M471
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$0/$0	$0/$0	$0	$300/$600	$1,000/$2,000	$0/$0
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$2,000/$4,000	$2,000/$4,000	$1,500/$3,000	$1,000/$3,000	$3,000/$6,000	$3,000/$6,000
PROFESSIONAL SERVICES						
Primary Care* visit co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$25	$25	$0	$20	$30	$0
Urgent Care co-pay	$25	$25	$0	$20	$30	$0
Prenatal, postnatal office visit co-pay	$0	$0	$0	$20	$30	$0
Specialists/Consultants co-pay	$25	$25	$0	$20	$30	$100
						Non-Hosp/OPH**
Scans: CT, CAT, MRI, PET etc.	$0	$0	$0	10% after Ded	20% after Ded	$300/$750
Laboratory Procedures	$0	$0	$0	10% after Ded	20% after Ded	$0/$150
Diagnostic X-rays	$0	$0	$0	10% after Ded	20% after Ded	$75/$225
Infertility (Refer to Plan Document)	50%	50%	Co-pay applies	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	$0	$0	$0	0% after Ded Ded Waived	0% after Ded Ded Waived	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES						
Emergency Room visit (copay waived if admitted) - **Avg Cost: $2,847 | $100+10%: $375 | $100+20%: $649**	$100	$100	$100	10% after Ded $100 co-pay	20% after Ded $100 co-pay	$700
Inpatient Hospital (preauthorization required) - **Avg Cost for one day: $6,067 | 10%: $607 | 20%: $1,213**	$500/admit	$500/admit	$0	10% after Ded	20% after Ded	$600/day
Surgery, Outpatient (performed in Surgery Center)	$150	$150	$0	10% after Ded	20% after Ded	$600
Surgery, Outpatient (performed in a Hospital) - limits may apply	$300	$300	$0	10% after Ded	20% after Ded	$1,800
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
INPATIENT: Facility Based Care (preauth required)	$500/admit	$500/admit	$0	10% after Ded	20% after Ded	$600/day
OUTPATIENT: Facility Based Care (preauth required)	$25	$25	$0	10% after Ded	20% after Ded	$0
OTHER SERVICES						
Ambulance (Ground or Air)	$100	$100	$50	10% after Ded $100 co-pay	20% after Ded $100 co-pay	$700
Acupuncture - Limits apply	$10/30 visits combined w/chiro	$10/30 visits combined w/chiro	$10/30 visits (through ASH) combined w/chiro	10% after Ded	20% after Ded	$0
Chiropractic - Limits apply	$10/30 visits combined w/acu	$10/30 visits combined w/acu	$10/30 visits (through ASH) combined w/acu	10% after Ded	20% after Ded	$0
Physical and Occupational Therapy - Limits apply	$25	$25	$0	10% after Ded	20% after Ded	$0
Durable Medical Equipment (DME)	20%	20%	no charge	10% after Ded	20% after Ded	$0
Hearing Aids	50% Coinsurance 1 device/24 months	50% Coinsurance 1 device/24 months	amount in excess of $500 allowance every 36 months	10% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	$0 plus the amount in excess of $700 allowance/24 months

*Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

PHARMACY BENEFITS

Plan	**Rx 5-20**	**Rx 5-20**	**$5 Rx (Non-Marketed)**	**Rx 7-25**	**Rx 5-20**	**Rx 9-35 PC**
Pharmacy Benefit Manager	**Navitus**	**Navitus**	**Kaiser**	**Navitus**	**Navitus**	**Navitus**
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$1,500/$2,500	Included w/ Med OOP Max	$1,500/$2,500	$1,500/$2,500	$2,500/$3,500
Generic co-pay/30 days supply	$0 at Costco‡ $5 at Other Network	$0 at Costco‡ $5 at Other Network	$5 up to 100 day supply	$0 at Costco‡ $7 at Other Network	$0 at Costco‡ $5 at Other Network	$0 at Costco‡ $9 at Other Network
Brand co-pay/30 days supply	$20	$20	$5 up to 100 day supply	$25	$20	$35
Specialty co-pay/up to 30 days supply	$20 Must Use Navitus Mail	$20 Must Use Navitus Mail	$5 up to 30 day supply	$25 Must Use Navitus Mail	$20 Must Use Navitus Mail	$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50‡	$0-$50‡	$5-$5/up to 100 day supply	$0-$60‡	$0-$50‡	$0-$90‡
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Employee cost/payroll deduction, if applicable, can be requested from the district.

‡Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.