Sylvan Union School District
FINAL 2020 HMO Benefit and Rates Comparison

	2020 Kaiser Permanente HMO Plans		
	Current	**Current**	**New for 2020**
Plan Name	High Plan	Mid Plan	Low HDHP
Annual Deductible/Individual	$0	$0	$2,700
Annual Deductible for Family Individual member max/Family max	$0	$0	$2,800/$5,450
Office Visit/Exam/Rehab Therapy	$15 copay	$30 copay	100% after cal year deductible
Outpatient Specialist Visit	$15 copay	$30 copay	100% after cal year deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$2,700
Annual Out-of-Pocket Limit/Family Individual member max/Family max	$3,000	$6,000	$2,700/$5,450
Diagnostic X-ray & Lab Tests	$0 copay	$10 copay	100% after cal year deductible
Complex Imaging (MRI, CT, PET)	$0 copay	$50 copay	100% after cal year deductible
Inpatient Hospitalization	$0 copay	$500 copay/admit	100% after cal year deductible
Outpatient Facility Charge (per procedure)	$15 copay	$250 copay	100% after cal year deductible
Emergency Room (waived if admitted)	$100 copay	$100 copay	100% after cal year deductible
Urgent Care Facility	$15 copay	$30 copay	100% after cal year deductible
Prescription Drug Benefits			
Generic	$10 copay	$15 copay	100% after cal year deductible
Brand (Formulary/Preferred)	$35 copay	$35 copay	100% after cal year deductible
Brand (Non-Formulary/Non-preferred)	$35 copay	$35 copay	100% after cal year deductible
Preferred Specialty (30-day supply)	$35 copay	$35 copay	100% after cal year deductible
Number of Days Supply	100 days	30 days	30 days
Mail Order			
Generic	$10 copay	$30 copay	100% after cal year deductible
Brand (Formulary/Preferred)	$35 copay	$70 copay	100% after cal year deductible
Brand (Non-Formulary/Non-preferred)	$35 copay	$70 copay	100% after cal year deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days

Note: As requested, this is a brief summary that does not include Out-of-Pocket maximums and other important benefits

EE	**$652.03**	**$642.75**	**$421.85**
EE + 1 Dep	**$1,304.06**	**$1,285.50**	**$843.69**
EE + Family	**$1,845.25**	**$1,818.99**	**$1,236.01**
	0.00%	**0.00%**	**0.00%**

Sylvan Union School District
FINAL 2020 HMO Benefit and Rates Comparison

	2020 Sutter Health Plus HMO Plans		
	New for 2020	**New for 2020**	**New for 2020**
Plan Name	High Plan ML26	Mid Plan ML27	Low HDHP
Annual Deductible/Individual	$0	$0	$2,500
Annual Deductible for Family Individual member max/Family max	$0	$0	$2,800/$5,,000
Office Visit/Exam/Rehab Therapy	$10 copay	$25 copay	80% after cal year deductible
Outpatient Specialist Visit	$10 copay	$25 copay	80% after cal year deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$2,500	$4,000
Annual Out-of-Pocket Limit/Family Individual member max/Family max	$3,000	$5,000	$4,000/$8,000
Diagnostic X-ray & Lab Tests	$10 copay	$25 copay lab $15 copay x-ray	80% after cal year deductible
Complex Imaging (MRI, CT, PET)	$50 copay	$50 copay	80% after cal year deductible
Inpatient Hospitalization	$250 copay /admit	$500 copay/ admit	80% after cal year deductible
Outpatient Facility Charge (per procedure)	$10 copay	$10 copay	80% after cal year deductible
Emergency Room (waived if admitted)	$100 copay	$150 copay	80% after cal year deductible
Urgent Care Facility	$10 copay	$25 copay	80% after cal year deductible
Prescription Drug Benefits			
Generic	$10 copay	$10 copay	$10 copay after cal year deductible
Brand (Formulary/Preferred)	$30 copay	$30 copay	$30 copay after cal year deductible
Brand (Non-Formulary/Non-preferred)	$60 copay	$60 copay	$60 copay after cal year deductible
Preferred Specialty (30-day supply)	20% copay; $250 max	20% copay; $250 max	20% copay; $100 max after cal year deductible
Number of Days Supply	30 days	30 days	30 days
Mail Order			
Generic	$20 copay	$20 copay	$20 copay after cal year deductible
Brand (Formulary/Preferred)	$60 copay	$60 copay	$60 copay after cal year deductible
Brand (Non-Formulary/Non-preferred)	$120 copay	$120 copay	$120 copay after cal year deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days

Note: As requested, this is a brief summary that does not include Out-of-Pocket maximums and other important benefits

EE	**$749.72**	**$717.52**	**$517.20**
EE + 1 Dep	**$1,499.44**	**$1,435.05**	**$1,034.28**
EE + Family	**$2,122.25**	**$2,031.13**	**$1,463.68**
	6.29%	**6.29%**	**6.33%**