



Sylvan Union School District FINAL 2020 HMO Benefit and Rates Comparison

Plan Name	2020 Kaiser Permanente HMO Plans		
	Current	Current	New for 2020
	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%

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.



Sylvan Union School District FINAL 2020 HMO Benefit and Rates Comparison

Plan Name	2020 Sutter Health Plus HMO Plans		
	New for 2020	New for 2020	New for 2020
	High Plan ML26	Mid Plan ML27	Low HDHP
Annual Deductible/Individual	\$0	\$0	\$2,500
Annual Deductible for Family	\$0	\$0	\$2,800/\$5,000
Individual member max/Family max			
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	\$3,000	\$5,000	\$4,000/\$8,000
Individual member max/Family max			
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%

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