SRCS Current Medical Plans & PERS Medical Plans

SANTA ROSA CITY SCHOOLS

KAISER PERMANENTE®

SANTA ROSA CITY OF SCHOOLS BENEFITS COMPARISON CHART – Active Employees Effective 7/1/2019 – 6/30/2020

These are Grandfathered Plans	Traditional HMO HIGH Plan	Deductible HMO MID Plan	Deductible Plan LOW HSA	Deductible Plan LOW/LOW HSA
Annual Deductible: Self Only / Indv / Family	None / None / None	$500 / $500 / $1,000	$1350 / $1,350 / $2,700	$2700 / $2700 / $5,450
Maximum Out-Of-Pocket: Self Only / Indv / Family	$1,500 / $1,500 / $3,000	$3,000 / $3,000 / $6,000	$3,000 / $3,000 / $6,000	$5,250 / $5,250 / $10,500
Maximum Lifetime Benefit	None / None	None / None	None / None	None / None
		* Benefit applies to deductible	* Benefit applies to deductible	* Benefit applies to deductible
Hospital Inpatient (all services rendered while hospitalized)	**$250 per admit**	**20% per admit ***	**$250 per admit ***	**30% per admit ***
Outpatient (specialty, routine and urgent care) **Preventive exams**	**$15 per visit / $15 spec** **No charge**	**$20 per visit / $20 spec**	**$20 per visit / $20 spec ***	**$30 per visit / $30 spec *** **No charge**
Well-child preventive care visits (23 months or younger)	No charge	$10 per visit	$10 per visit	No charge
Scheduled prenatal care and first postpartum visit	No charge	$10 per visit	$10 per visit	No charge
Outpatient surgery	$15 per procedure	20% per procedure *	$150 per procedure *	30% per procedure *
Allergy Injections / Immunizations	$5 per visit	No charge *	$5 per visit *	$5 per visit *
X-rays and Lab tests	No charge	$10 per encounter *	$10 per encounter *	$10 per encounter *
Ambulance services	$50 per trip	$150 per trip *	$100 per trip *	$100 per trip *
Emergency department visits	$50 per visit	20% per visit *	$100 per visit *	30% per visit *
Outpatient Prescription Drugs (pharmacy and mail order)	**$10 gen / $30 brand / $30 spec, $20 gen / $60 brand MOI**	**$10 gen / $30 brand / $30 spec**	**$10 gen / $30 brand / $30 spec, $20 gen / $60 brand MOI ***	**$10 gen / $30 brand / $30 spec, $20 gen / $60 brand MOI ***
Days supply / Deductible	30 days, 30 days spec, 100 days MOI	100 days, 30-day spec Brand/Specialty $100 deductible	30 days, 30 days spec, 100 days MOI	30 days, 30 days spec, 100 days MOI
Mental Health Services				
Inpatient psychiatric care / days per calendar year	$250 per admit	20% per admit *	$250 per admit *	30% per admit *
Outpatient individual therapy visits	$15 per visit	$20 per visit	$20 per visit *	$30 per visit *
Outpatient group therapy visits	$7 per visit	$10 per visit	$10 per visit *	$15 per visit *
Chemical Dependency Services				
Inpatient detoxification	$250 per admit	20% per admit *	$250 per admit *	30% per admit *
Outpatient individual therapy visits	$15 per visit	$20 per visit	$20 per visit *	$30 per visit *
Outpatient group therapy visits	$5 per visit	$5 per visit	$5 per visit *	$5 per visit *
Transitional Residential Recovery Services	$100 per admit	20% per admit *	$100 per admit *	30% per admit *
Infertility Services				
Covered services related to the diagnosis and treatment of infertility	50% per visit	50% per visit	100% per visit	100% per visit
Additional Benefits				
Supplemental Durable Medical Equipment	No charge	20% per item	20% per item *	20% per item *
Skilled Nursing, Home and Hospice Care	No charge	20% per admit *	$250 per admit *	30% per admit *
Optical eyewear (frames, lenses, contact lenses)	$175 per 24 months	$175 per 24 months	Not covered	Not covered
Hearing aids	Not covered	Not covered	Not covered	Not covered
Chiropractic	$15 per visit to 20 visits	$15 per visit to 20 visits	Not covered	Not covered
Subscriber only	**$861.55**	**$678.71**	**$531.92**	**$415.60**
Subscriber + 1 dependent	**$1,852.32**	**$1,459.23**	**$1,143.63**	**$893.55**
Subscriber + 2 or more dependents	**$2,541.55**	**$2,002.19**	**$1,569.16**	**$1,226.03**

This is a brief summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits and it does not list all benefits, Copayments, and Coinsurance. Please refer to the Evidence of Coverage to learn about coverage (including exclusions and limitations) and other benefits, Copayments, and Coinsurance that are not included in this summary. Note: We cover benefits in accord with applicable law (for example, diabetes supplies).
MOI: Mail Order Incentive

Current SRCS Kaiser Medical Plans

CalPERS Health Plan Benefit Comparison—**Basic Plans**

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans					
BENEFITS	**Anthem Blue Cross** Traditional	**Health Net** Salud y Más & SmartCare	**Kaiser Permanente**			**Western Health Advantage HMO**
Calendar Year Deductible						
Individual	N/A	N/A	N/A			N/A
Family	N/A	N/A	N/A			N/A
Maximum Calendar Year Co-pay or Co-insurance *(excluding pharmacy)*						
Individual	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)			$1,500 (co-pay)
Family	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)			$3,000 (co-pay)
Hospital *(including Mental Health and Substance Abuse)*						
Deductible (per admission)	N/A	N/A	N/A			N/A
Inpatient	No Charge	No Charge	No Charge			No Charge
Outpatient Facility/ Surgery Services	No Charge	No Charge	$15			No Charge

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BENEFITS	PPO Basic Plans					
	PERS Select		PERS Choice		PERSCare	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
Individual	$1,000[1] (not transferable between plans)		$500 (not transferable between plans)		$500 (not transferable between plans)	
Family	$2,000[1] (not transferable between plans)		$1,000 (not transferable between plans)		$1,000 (not transferable between plans)	
Maximum Calendar Year Co-pay or Co-insurance *(excluding pharmacy)*						
Individual	$3,000 (co-insurance)	N/A	$3,000 (co-insurance)	N/A	$2,000 (co-insurance)	N/A
Family	$6,000 (co-insurance)	N/A	$6,000 (co-insurance)	N/A	$4,000 (co-insurance)	N/A
Hospital *(including Mental Health and Substance Abuse)*						
Deductible (per admission)	N/A		N/A		$250	
Inpatient	20%[2]	40%	20%	40%	10%	40%
Outpatient Facility/ Surgery Services	20%[2]	40%	20%	40%	10%	40%

[1] Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).

[2] Coinsurance waived for deliveries if enrolled in Future Moms Program.

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans				
BENEFITS	Anthem Blue Cross Traditional HMO	Health Net Salud y Más & SmartCare	Kaiser Permanente		Western Health Advantage HMO
Emergency Services					
Emergency Room Deductible	N/A	N/A	N/A		N/A
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50		$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50		$50
Physician Services *(including Mental Health and Substance Abuse)*					
Office Visits (co-pay for each service provided)	$15	$15	$15		$15
Inpatient Visits	No Charge	No Charge	No Charge		No Charge
Outpatient Visits	$15	$15	$15		$15
Urgent Care Visits	$15	$15	$15		$15
Preventive Services	No Charge	No Charge	No Charge		No Charge
Surgery/Anesthesia	No Charge	No Charge	No Charge		No Charge
Diagnostic X-Ray/Lab					
	No Charge	No Charge	No Charge		No Charge

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BENEFITS	PPO Basic Plans					
	PERS Select		PERS Choice		PERSCare	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services						
Emergency Room Deductible	$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)	
Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)	
Non-Emergency	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%
Physician Services *(including Mental Health and Substance Abuse)*						
Office Visits (co-pay for each service provided)	$35 [1, 2]	40%	$20 [2]	40%	$20 [2]	40%
Inpatient Visits	20%	40%	20%	40%	10%	40%
Outpatient Visits	$20	40%	$20	40%	$20	40%
Urgent Care Visits	$35	40%	$35	40%	$35	40%
Preventive Services	No Charge	40%	No Charge	40%	No Charge	40%
Surgery/Anesthesia	20%	40%	20%	40%	10%	40%
Diagnostic X-Ray/Lab						
	20%	40%	20%	40%	10%	40%

[1] Reduced to $10 if enrolled with personal doctor.

[2] $35 for specialist visit.

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans				
BENEFITS	**Anthem Blue Cross Traditional HMO**	**Health Net Salud y Más & SmartCare**	**Kaiser Permanente**		**Western Health Advantage HMO**
Prescription Drugs					
Deductible	N/A	N/A	N/A		N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand: $20		Generic: $5 Brand Formulary: $20 Non-Formulary: $50
Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	N/A		Generic: $10 Brand Formulary: $40 Non-Formulary: $100
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand: $40 (31-100 day supply)		Generic: $10 Brand Formulary: $40 Non-Formulary: $100
Mail order maximum co-payment per person per calendar year	$1,000	$1,000	N/A		$1,000
Durable Medical Equipment					
	No Charge	No Charge	No Charge		No Charge

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BENEFITS	PPO Basic Plans					
	PERS Select		PERS Choice		PERSCare	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
Deductible	N/A		N/A		N/A	
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50	
Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100	
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100	
Mail order maximum co-payment per person per calendar year	$1,000		$1,000		$1,000	
Durable Medical Equipment						
	20%	40%	20%	40%	10%	40%
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment $1,000 or more)	

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans				
	Anthem Blue Cross Traditional HMO	Health Net Salud y Más & SmartCare	Kaiser Permanente		Western Health Advantage HMO
Infertility Testing/Treatment					
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges		50% of Covered Charges
Occupational / Physical / Speech Therapy					
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge		No Charge
Outpatient (office and home visits)	$15	$15	$15		$15
Diabetes Services					
Glucose monitors	No Charge	No Charge	No Charge		No Charge
Self-management training	$15	$15	$15		$15
Acupuncture					
	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)		$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic					
	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)		$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

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BENEFITS	PPO Basic Plans					
	PERS Select		PERS Choice		PERSCare	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment						
	Not Covered		Not Covered		Not Covered	
Occupational / Physical / Speech Therapy						
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge	
Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%
Diabetes Services						
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	$20	60%	$20	60%	$20	60%
Acupuncture	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%
Chiropractic	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%

2020 Health Maintenance Organization (HMO) Premiums

BASIC HMO PLANS	Single	2-Party	Family
		Region 1	
Anthem HMO Select	$868.98	$1,737.96	$2,259.35
Anthem HMO Traditional	1,184.84	2,369.68	3,080.58
Blue Shield Access+	1,127.77	2,255.54	2,932.20
Blue Shield Trio	833.00	1,666.00	2,165.80
Health Net SmartCare	1,000.52	2,001.04	2,601.35
Kaiser	768.49	1,536.98	1,998.07
UnitedHealthcare	899.94	1,799.88	2,339.84
Western Health Advantage	731.96	1,463.92	1,903.10
		Region 2	
Anthem HMO Select	$654.04	$1,308.08	$1,700.50
Anthem HMO Traditional	934.95	1,869.90	2,430.87
Blue Shield Access+	909.87	1,819.74	2,365.66
Health Net Salud y Mas	435.14	870.28	1,131.36
Health Net SmartCare	719.26	1,438.52	1,870.08
Kaiser	645.24	1,290.48	1,677.62
Sharp	606.02	1,212.04	1,575.65
UnitedHealthcare	671.60	1,343.20	1,746.16
		Region 3	
Anthem HMO Select	$619.93	$1,239.86	$1,611.82
Anthem HMO Traditional	902.63	1,805.26	2,346.84
Blue Shield Access+	813.17	1,626.34	2,114.24
Blue Shield Trio	624.93	1,249.86	1,624.82
Health Net Salud y Mas	392.31	784.62	1,020.01
Health Net SmartCare	648.42	1,296.84	1,685.89
Kaiser	664.39	1,328.78	1,727.41
UnitedHealthcare	668.31	1,336.62	1,737.61
		Out of State	
Kaiser Out of State	$955.19	$1,990.38	$2,587.49

MEDICARE HMO PLANS *	Single	2-Party	Family
		All Regions	
Anthem Select	$388.15	$776.30	$1,164.45
Anthem Traditional	388.15	776.30	1,164.45
Kaiser	339.43	678.86	1,018.29
Kaiser Out of State	339.43	678.86	1,018.29
UnitedHealthcare	327.03	654.06	981.09

* Dental and/or vision benefits for Medicare HMO enrollees are available for an additional premium.

2020 Preferred Provider Organization (PPO) Premiums

BASIC PPO PLANS	Single	2-Party	Family
	Region 1		
Anthem EPO Del Norte	$861.18	$1,722.36	$2,239.07
Blue Shield EPO	1,127.77	2,255.54	2,932.20
PERS Choice	861.18	1,722.36	2,239.07
PERS Select	520.29	1,040.58	1,352.75
PERSCare	1,133.14	2,266.28	2,946.16
PORAC	774.00	1,699.00	2,199.00
	Region 2		
PERS Choice	$736.28	$1,472.56	$1,914.33
PERS Select	451.54	903.08	1,174.00
PERSCare	986.66	1,973.32	2,565.32
PORAC	749.00	1,499.00	1,960.00
	Region 3		
PERS Choice	$710.29	$1,420.58	$1,846.75
PERS Select	435.74	871.48	1,132.92
PERSCare	931.12	1,862.24	2,420.91
PORAC	699.00	1,399.00	1,894.00
	Out of State		
PERS Choice	$709.66	$1,419.32	$1,845.12
PERSCare	882.03	1,764.06	2,293.28
PORAC	899.00	1,850.00	2,223.00

MEDICARE PPO PLANS	Single	2-Party	Family
	All Regions		
PERS Choice	$351.39	$702.78	$1,054.17
PERS Select	351.39	702.78	1,054.17
PERSCare	384.78	769.56	1,154.34
PORAC	513.00	1,022.00	1,635.00

Public agency and school health regions

Region 1

Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba

Region 2

Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura

Region 3

Los Angeles, Riverside, and San Bernardino