Sylvan Union School District
2019 HMO Benefit and Rates Comparison

	2019 Kaiser Permanente HMO Plans			2019 Sutter Health Plus HMO Plans		
Plan Name	High Plan	Low Plan	HDHP	High Plan	Low Plan	HDHP
General Plan Information						
Annual Deductible/Individual	$0	$0	$2,700 per calendar year	$0	$0	$2,500 per calendar year (self only)
Annual Deductible/Family	$0	$0	$2,700 (Each member in a family of two or more members) $5,450 (Entire family of two or more members) per cal year	$0	$0	$2,700 (Each member in a family of two or more members) $5,000 (Entire family of two or more members) per calendar year
Coinsurance	100%	100%	100% after cal year deductible	100%	100%	80%
Office Visit/Exam	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Outpatient Specialist Visit	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$2,700	$1,500	$2,500	$4,000
Annual Out-of-Pocket Limit/Family	$3,000	$6,000	$2,700 (Each member in a family of two or more members) $5,450 (Entire family of two or more members) per cal year	$3,000	$5,000	$4,000 (Each member in a family of two or more members) $8,000 (Entire family of two or more members) per cal year
Deductible Included in Out-of-Pocket Limits	N/A	N/A	Yes	N/A	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	No	Yes	Yes	Yes
Outpatient Services						
Preventive Services						
Well-Child Care	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Immunizations	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Well Woman Exams	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Mammograms	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Adult Periodic Exams with Preventive Tests	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Diagnostic X-Ray and Lab Tests	100%	$10 copay x-ray & Lab; $50 per procedure MRI, CT and PET	100% after cal year deductible	$10 copay standard x-ray & lab ; $50 copay for complex imaging (CT, PET, MRI scans)	$15 copay standard x-ray & lab; $50 copay complex Imaging (CT, PET, MRI scans)	80% covered after deductible
Maternity Care						
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100% (deductible does not apply)	100%	100%	100% covered (deductible waived)
Inpatient Hospital Services						
Inpatient Hospitalization	100%	$500 copay per admit	100% after cal year deductible	$250 copay per day for days 1 - 5	$500 copay per day for days 1 - 5	80% covered after deductible
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	$500 copay per admit	100% after cal year deductible	$250 copay per day for days 1 - 5	$500 copay per day for days 1 - 5	80% covered after deductible
Surgical Services						
Outpatient Facility Charge	$15 copay per procedure	$250 copay per procedure	100% after cal year deductible	$10 copay	$10 copay	80% covered after deductible

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Emergency Services						
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	100% after cal year deductible	$100 copay (waived if admitted)	$150 copay (waived if admitted)	80% covered after deductible
Ambulance						
Air	100%	$150 copay per trip	100% after cal year deductible	$100 copay per trip	$150 copay per trip	100% covered after deductible
Ground	100%	$150 copay per trip	100% after cal year deductible	$100 copay per trip	$150 copay per trip	100% covered after deductible
Urgent Care						
Urgent Care Facility	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Mental Health Benefits						
Inpatient Care	100%	$500 copay per admit	100% after cal year deductible	$250 copay per day for days 1 - 5	$500 copay per day for days 1 - 5	80% covered after deductible
Outpatient Care	$15 copay individual therapy; $7 copay group therapy	$30 copay individual therapy; $15 copay group therapy	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Substance Abuse						
Inpatient Care						
Inpatient Hospitalization	100%	$500 copay per admit	100% after cal year deductible	$250 copay per day for days 1 - 5	$500 copay per day for days 1 - 5	80% covered after deductible
Inpatient Detoxification Services	100%	$500 copay per admit	100% after cal year deductible	$250 copay per day for days 1 - 5	$500 copay per day for days 1 - 5	80% covered after deductible
Outpatient Care						
Outpatient Services	$15 copay individual therapy; $5 copay group therapy	$30 copay individual therapy; $5 copay group therapy	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Prescription Drug Benefits						
Prescription Drug Deductible	N/A	N/A	Subject to plan deductible	None	None	Subject to plan deductible
Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max
Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max	Will accrue to annual OOP Max
Generic	$10 copay	$15 copay	100% after cal year deductible	$10 copay	$10 copay	$10 copay after deductible
Preferred Specialty	$35 copay (30 day supply)	$35 copay 30 day supply	100% after cal year deductible	20% coinsurance up to $100 per Rx	20% coinsurance up to $100 per Rx	20% up to $100 per Rx after deductible
Brand (Formulary/Preferred)	$35 copay	$35 copay	100% after cal year deductible	$30 copay	$30 copay	$30 copay after deductible
Brand (Non-Formulary/Non-preferred)	$35 copay	$35 copay	100% after cal year deductible	$60 copay	$60 copay	$60 copay after deductible
Number of Days Supply	100 days	30 days	30 days	30 days	30 days	30 days
Mail Order						
Generic	$10 copay	$30 copay	100% after cal year deductible	$20 copay	$20 copay	$20 copay after deductible
Brand (Formulary/Preferred)	$35 copay	$70 copay	100% after cal year deductible	$60 copay	$60 copay	$60 copay after deductible
Brand (Non-Formulary/Non-preferred)	$35 copay	$70 copay	100% after cal year deductible	$120 copay	$120 copay	$120 copay after deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days	100 days	100 days

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Other Services and Supplies						
Durable Medical Equipment & Prosthetic Devices	100%	50% per item	100% after cal year deductible	80% covered	80% covered	80% covered after deductible
Home Health Care	100% up to 100 visits per cal year	100% up to 100 visits per cal year	100% after cal year deductible	100% ; Limited to 100 visits per cal year	100% covered; Limited to 100 visits per cal year	100% covered after deductible; Limited to 100 visits per cal year
Skilled Nursing or Extended Care Facility	100% up to 100 days per benefit period	100% up to 100 days per benefit period	100% after cal year deductible	$100 copay per day for days 1 - 5; Limited to 100 days per cal year	$250 copay per day for days 1 - 5; Limited to 100 days per cal year	80% covered after deductible; Limited to 100 days per cal year
Hospice Care	100%	100%	100% after cal year deductible	100%	100%	100% covered after deductible
Chiropractic Services	$10 copay; 30 visits	$10 copay; 30 visits	$10 copay; 20 visits	$10 copay; 30 visits	$10 copay; 30 visits	Not covered
Acupuncture	$10 copay; 30 visits	$10 copay; 30 visits	Not covered	$10 copay; 30 visits	$10 copay; 30 visits	80% covered after deductible (only covered when authorized for nausea or as part of a chronic pain management program)
Vision						
Examination	100%	100%	100% after cal year deductible	100% for preventive screenings	100% for preventive screening	100% covered (deductible waived) covered for preventive screenings
Materials	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing						
Screening	100%	100%	100% (deductible does not apply)	100% for preventive screenings	100% covered for preventive screenings	100% covered (deductible waived) for preventive screenings
Aid(s)	Not covered	Not covered	Not covered	Not covered		Not covered
Infertility						
Diagnosis	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Treatment	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services						
Physical	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Occupational	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
Speech	$15 copay	$30 copay	100% after cal year deductible	$10 copay	$25 copay	80% covered after deductible
RATES						
EE	$652.03	$642.75	$421.85	$705.31	$675.03	$486.38
EE + 1 Dep	$1,304.06	$1,285.50	$843.69	$1,410.64	$1,350.09	$972.75
EE + Family	$1,845.25	$1,818.99	$1,236.01	$1,996.58	$1,910.89	$1,376.65

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