

**Sacramento City Unified School District - Effective January 1, 2019**

**Kaiser/WHA/Sutter - Plan Comparison - Classified Employees & Early Retirees**

	Kaiser		Western Health Advantage		Sutter Health Plus	
Plan Name	HMO	HSA \$1,800 Deductible	HMO	HSA \$1,800 Deductible	HMO	HSA \$1,500 Deductible
<b>General Plan Information</b>						
Annual Deductible/Individual	\$0	\$2,600	\$0	\$1,800	\$0	\$1,500
Annual Deductible/Family	\$0	\$5,200	\$0	\$3,600	\$0	\$3,000
Coinsurance	N/A	100%	100%	100%	100%	100%
Office Visit/Exam	\$10 copay	No Charge*	\$15 copay	No Charge*	\$10 copay	No Charge*
Outpatient Specialist Visit	\$10 copay	No Charge*	\$15 copay	No Charge*	\$10 copay	No Charge*
Annual Out-of-Pocket Limit/Individual	\$1,500	\$2,600	\$1,500	\$1,800	\$750	\$3,000
Annual Out-of-Pocket Limit/Family	\$3,000	\$5,200	\$2,500	\$3,600	\$1,500	\$6,000
Deductible Included in Out-of-Pocket Limits	N/A	Yes	N/A	Yes	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes	Yes	Yes
<b>Outpatient Services</b>						
<b>Preventive Services</b>						
Well-Child Care, Immunizations, Well Woman Exams, Mammograms, Adult Periodic Exams with Preventive Tests	\$0 copay	No Charge - Deductible Waived	\$0 copay	No Charge - Deductible Waived	\$0 copay	No Charge - Deductible Waived
Diagnostic X-Ray and Lab Tests Non-Preventive)	\$0 copay	No Charge*	\$0 copay	No Charge*	Lab-\$10 copay; X-Ray-\$0 copay \$50 copay-advanced imaging	No Charge*
<b>Maternity Care</b>						
Pregnancy and Maternity Care (Pre-Natal Care)	\$0 copay	No Charge - Deductible Waived	\$0 copay	No Charge - Deductible Waived	\$0 copay	No Charge - Deductible Waived
<b>Inpatient Hospital Services</b>						
Inpatient Hospitalization	\$0 copay	No Charge*	\$0 copay	No Charge*	\$0 copay	\$50/admission *
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	\$0 copay	No Charge*	\$0 copay	No Charge*	\$0 copay	\$50/admission *
<b>Surgical Services</b>						
Outpatient Facility Charge	\$10 copay per procedure	No Charge*	\$100 copay/visit in an outpatient surgery facility	No Charge*	\$0 copay	No Charge*
<b>Emergency Services</b>						
Emergency Room (waived if admitted)	\$75 copay	No Charge*	\$100 copay	No Charge*	\$30 copay	No Charge*
<b>Ambulance</b>						
Air	\$0 copay	No Charge*	\$0 copay	No Charge*	\$30 copay per trip	No Charge*
Ground	\$0 copay	No Charge*	\$0 copay	No Charge*	\$30 copay per trip	No Charge*
<b>Urgent Care</b>						
Urgent Care Facility	\$10 copay	No Charge*	\$20 copay	No Charge*	\$15 copay	No Charge*
<b>Mental Health Benefits</b>						
Inpatient Care	\$0 copay	No Charge*	\$0 copay**	No Charge*	\$0 copay	No Charge*
Outpatient Care	\$10 copay individual therapy; \$5 copay group therapy	No Charge*	\$15 copay	No Charge*	\$10 copay individual therapy; \$5 copay group therapy	No Charge*

*\* After Deductible; \*\* Prior authorization required*

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<b>Plan Name</b>	<b>HMO</b>	<b>HSA \$1,800 Deductible</b>	<b>HMO</b>	<b>HSA \$1,800 Deductible</b>	<b>HMO</b>	<b>HSA \$1,500 Deductible</b>
<b>Substance Abuse</b>						
Inpatient Hospitalization	\$0 copay	No Charge*	\$0 copay**	No Charge*	\$0 copay**	No Charge*
Inpatient Detoxification Services	\$0 copay	No Charge*	\$0 copay**	No Charge*	\$0 copay**	No Charge*
<b>Outpatient Care</b>						
Outpatient Services	\$10 copay individual therapy; \$5 copay group therapy	No Charge*	\$15 copay	No Charge*	\$10 copay individual therapy; \$5 copay group therapy	No Charge*
<b>Prescription Drug Benefits</b>						
Generic	\$10 copay	No Charge*	\$10 copay	No Charge*	\$5 copay	No Charge*
Brand (Formulary/Preferred)	\$10 copay	No Charge*	\$20 copay	No Charge*	\$20 copay	No Charge*
Brand (Non-Formulary/Non-preferred)	\$10 copay when approved	No Charge* when approved	\$30 copay	No Charge*	\$40 copay	No Charge*
Number of Days Supply	100 days	100 days	30 days	30 days	30 days	30 days
<b>Mail Order</b>						
Generic	\$10 copay	No Charge*	\$25 copay	No Charge*	\$10 copay	No Charge*
Brand (Formulary/Preferred)	\$10 copay	No Charge*	\$50 copay	No Charge*	\$40 copay	No Charge*
Brand (Non-Formulary/Non-preferred)	\$10 copay when approved	No Charge* when approved	\$75 copay	No Charge*	\$80 copay	No Charge*
Number of Days Supply for Mail Order	100 days	100 days	Up to 90 days	90 days	100 days	100 days
<b>Other Services and Supplies</b>						
Durable Medical Equipment & Prosthetic Devices	\$0 copay - In accordance with DME formulary	No Charge* - In accordance with DME formulary	20% copay	No Charge*	\$0 copay**	No Charge*
Home Health Care (Up to 100 visits/calendar year)	\$0 copay	No Charge*	\$0 copay	No Charge*	\$0 copay	No Charge*
Skilled Nursing or Extended Care Facility (Up to 100 days/benefit period)	\$0 copay	No Charge*	\$0 copay	No Charge*	\$0 copay	No Charge*
Hospice Care	\$0 copay	No Charge*	\$0 copay	No Charge After Deductible	\$0 copay	No Charge*
Chiropractic Services	\$10 copay Up to 30 visits per year	Not covered	\$15 copay - Limited to 20 medically necessary visits per cal year	\$15 copay (does not apply to annual out of pocket maximum)	\$10 copay - Limited to 30 visits per calendar year	Not covered
Acupuncture	\$10 copay Must be referred by physician	No Charge*; Must be referred by physician	\$15 copay - Limited to 20 medically necessary visits per cal year	\$15 copay (does not apply to annual out of pocket maximum)	Not covered	Not covered
<b>Hearing</b>						
Screening Aid(s)	\$0 copay for preventive screenings only Not covered	No Charge - Deductible Waived Not covered	\$0 copay for preventive screenings only Not covered	No Charge for Preventive Screenings - Deductible Waived Not covered	\$0 copay for preventive screenings Not covered	No Charge* Not covered
<b>Outpatient Rehabilitative Therapy Services</b>						
Physical	\$10 copay	No Charge*	\$15 copay	No Charge*	\$0 copay	No Charge*
Occupational	\$10 copay	No Charge*	\$15 copay	No Charge*	\$0 copay	No Charge*
Speech	\$10 copay	No Charge*	\$15 copay	No Charge*	\$0 copay	No Charge*

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