

Sacramento City Unified School District - Effective July 1, 2020

HealthNet/Kaiser HMO Plan Comparison - Certificated Employees & Early Retirees Only

	HealthNet	Kaiser
Plan Name	HMO	HMO
General Plan Information		
Annual Deductible/Individual	\$0 copay	\$0 copay
Annual Deductible/Family	\$0 copay	\$0 copay
Coinsurance	N/A	N/A
Office Visit/Exam	\$15 copay	\$10 copay
Outpatient Specialist Visit	\$15 copay	\$10 copay
Annual Out-of-Pocket Limit/Individual	\$1,000	\$1,500
Annual Out-of-Pocket Limit/Family	\$2,500	\$3,000
Deductible Included in Out-of-Pocket Limits	N/A	N/A
Lifetime Plan Maximum	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes
Outpatient Services		
Preventive Services		
Well-Child Care, Immunizations, Well Woman Exams, Mammograms, Adult Periodic Exams with Preventive Tests	\$0 copay	\$0 copay
Diagnostic X-Ray and Lab Tests	\$0 copay	\$0 copay
Outpatient Facility Charge	\$0 copay *	\$10 copay per procedure
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	\$0 copay	\$0 copay
Inpatient Hospital Services		
Inpatient Hospitalization	\$0 copay *	\$0 copay
Emergency Services		
Emergency Room (waived if admitted)	\$75 copay	\$75 copay
Ambulance - Air/Ground	\$0 copay	\$0 copay
Urgent Care		
Urgent Care Facility	\$20 copay	\$10 copay
Mental Health Benefits		
Inpatient Care	\$0 copay *	\$0 copay
Outpatient Care	\$0 copay	\$10 copay individual therapy; \$5 copay group therapy
Substance Abuse		
Inpatient Hospitalization/Detoxification Services	\$0 copay *	\$0 copay
Outpatient Services	\$0 copay	\$10 copay individual therapy; \$5 copay group therapy
Prescription Drug Benefits		
Pharmacy Out-of-Pocket Limit (Individual/Family)	\$2,000/\$4,000	
Generic	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$20 copay	\$10 copay
Brand (Non-Formulary/Non-preferred)	\$35 copay	\$10 copay when approved through exception process
Number of Days Supply	30 days	100 days
Mail Order		
Generic	\$20 copay	\$10 copay
Brand (Formulary/Preferred)	\$40 copay	\$10 copay
Brand (Non-Formulary/Non-preferred)	\$70 copay	\$10 copay when approved through exception process
Number of Days Supply for Mail Order	90 days	100 days
Other Services and Supplies		
Durable Medical Equipment & Prosthetic Devices	\$0 copay *	\$0 copay
Home Health Care (Up to 100 visits/calendar year)	\$0 copay *	\$0 copay
Skilled Nursing Facility (Up to 100 days/benefit period)	\$0 copay *	\$0 copay
Hospice Care	\$0 copay *	\$0 copay
Chiropractic Services	\$10 copay, Up to 30 visits/year \$15 copay * (if deemed medically necessary)	\$10 copay, Up to 30 visits per year
Acupuncture		\$10 copay *
Hearing		
Screening	\$0 copay	\$0 copay
Aid(s)	Not covered	Not covered
Outpatient Rehabilitative Therapy Services		
Physical	\$5 copay *	\$10 copay
Occupational	\$5 copay *	\$10 copay
Speech	\$5 copay *	\$10 copay

* Prior authorization required