Keenan & Associates

Sacramento City Unified School District - Effective January 1, 2020

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

	Kaiser		Western Health Advantage		Sutter Health Plus	
Plan Name	**HMO**	**HSA $2,700 Deductible**	**HMO**	**HSA $1,800 Deductible**	**HMO**	**HSA $1,500 Deductible**
General Plan Information						
Annual Deductible-Individual/Individual Family Member	$0	$2, 700	$0	$1,800/$2,800	$0	$1,500/$2,800
Annual Deductible/Family	$0	$5,400	$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, 700	$1,500	$1,800	$1,000	$3,000
Annual Out-of-Pocket Limit/Family	$3,000	$5,400	$2,500	$3,600	$2,000	$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
Outpatient Services						
Preventive Services						
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*
Maternity Care						
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
Inpatient Hospital Services						
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 *
Surgical Services						
Outpatient Facility Charge	$10 copay per procedure	No Charge*	$100 copay/visit in an outpatient surgery facility	No Charge*	$0 copay	No Charge*
Emergency Services						
Emergency Room (waived if admitted)	$75 copay	No Charge*	$100 copay	No Charge*	$50 copay	No Charge*
Ambulance						
Air	$0 copay	No Charge*	$0 copay	No Charge*	$50 copay per trip	No Charge*
Ground	$0 copay	No Charge*	$0 copay	No Charge*	$50 copay per trip	No Charge*
Urgent Care						
Urgent Care Facility	$10 copay	No Charge*	$20 copay	No Charge*	$10 copay	No Charge*
Mental Health Benefits						
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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Substance Abuse						
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*
Outpatient Care						
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*
Prescription Drug Benefits						
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
Mail Order						
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
Other Services and Supplies						
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
Hearing						
Screening	$0 copay for preventive screenings only	No Charge - Deductible Waived	$0 copay for preventive screenings only	No Charge for Preventive Screenings - Deductible Waived	$0 copay for preventive screenings	No Charge*
Aid(s)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services						
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*

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