SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP

Kaiser and Anthem Blue Cross Medical Plans

2019 Comparison

	KAISER PERMANENTE PLANS			ANTHEM BLUE CROSS PLANS				
	Traditional HMO **HIGH PLAN**	Deductible HMO **MID PLAN**	Deductible HMO **LOW PLAN**	Traditional HMO **HIGH PLAN**	Deductible HMO **MID PLAN**	Deductible HMO **LOW PLAN**	High Deductible PPO HSA **PPO HSA PLAN**	
Plan Details	*Kaiser HMO Plan Providers*			*Anthem HMO Providers*			*PPO*	*Non-PPO*
Annual Deductible (Ind/Fam)	None	$500 / $1,000	$3,000/$6,000	None	$250/$500	$500/$1,000	$2,700/$5,400	$3,000/$6,000
Out of Pocket Max (Ind/Fam)	$1,500/$3,000	$3,000/$6,000	$6,000/$12,000	$1,500/$3,000	$2,500/$5,000	$5,000/$10,000	$2,700/$5,400	$7,000/$14,000
Benefit Details								
Preventive Care	$0	$0 *(ded waived)*	$0 *(ded waived)*	$0	$0 *(ded waived)*	$0 *(ded waived)*	$0 *(ded waived)*	30% *(after ded)*
Office Visit	$20 Copay	$20 Copay *(ded waived)*	$40 Copay *(ded waived)*	$30 Copay	$30 Copay *(ded waived)*	$40 Copay *(ded waived)*	$0 *(after ded)*	30% *(after ded)*
Diagnostic Lab & Xray	$0	$10 Copay *(ded waived)*	$10 Copay *(ded waived)*	$0	10% hospital *(after ded)* [2]	30% hospital (after ded) [2]	$0 *(after ded)*	30% *(after ded)*
Inpatient Hospital	$500/admit	10% *(after ded)*	30% *(after ded)*	$750/admit	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	30% *(after ded)* [3]
Outpatient Surgery	$20 Copay	10% *(after ded)*	30% *(after ded)*	$0	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	30% *(after ded)*
Outpatient Rehab Therapy	$20 Copay	$20 Copay *(ded waived)*	$40 Copay *(ded waived)*	$30 Copay [6]	$30 Copay *(ded waived)* [6]	$40 Copay *(ded waived)* [6]	*$0 (after ded)* [4]	30% *(after ded)* [4]
Durable Medical Equipment	20%	20% *(ded waived)*	20% *(ded waived)*	$0	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	50% *(after ded)*
Home Health Care	$0 [5]	$0 *(ded waived)* [5]	$0 *(ded waived)* [5]	$30 Copay [7]	$30 Copay *(ded waived)* [7]	$40 Copay *(ded waived)* [7]	*$0 (after ded)* [4]	30% *(after ded)* [4]
Emergency Room	$125 Copay [1]	10% *(after ded)*	30% *(after ded)*	$150 Copay [1]	$150 Copay + 10% [1]	$250 Copay + 30% [1]	$0 *(after ded)*	
Ambulance	$75	$150 *(ded waived)*	$150 *(ded waived)*	$0	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	30% *(after ded)*
Mental Health Outpatient	$20 Copay	$20 Copay *(ded waived)*	$40 Copay *(ded waived)*	$30 Copay	$30 Copay *(ded waived)*	$40 copay *(ded waived)*	$0 *(after ded)*	30% *(after ded)*
Mental Health Inpatient	$500/admit	10% *(after ded)*	30% *(after ded)*	$750/admit	10% *(after ded)*	30% *(after ded)*	$0 *(after ded)*	30% *(after ded)* [3]
Prescription Drugs - Retail							Must satisfy Deductible before Rx copays apply	
Generic	$10	$10	$10	$10	$10	$10	$0 *(after ded)*	30% *(after ded)*
Formulary Brand	$25	$30	$30	$25	$30	$30	$0 *(after ded)*	30% *(after ded)*
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	$40	$50	$50	$0 *(after ded)*	30% *(after ded)*
Retail Supply	100-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Prescription Drugs - Mail Order								
Generic	$10	$20	$20	$10	$10	$10	$0 *(after ded)*	Not Covered
Formulary Brand	$25	$60	$60	$50	$60	$60	$0 *(after ded)*	Not Covered
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	$80	$100	$100	$0 *(after ded)*	Not Covered
Mail Order Supply	100-day supply	100-day supply	100-day supply	90-day supply	90-day supply	90-day supply	90-day supply	Not Covered
Specialty Pharmacy Drugs								
Generic/Formulary/Non-Form Self-Administered	$35	$35	$35	$10/$25/$40 Copays above apply	$10/$30/$50 Copays above apply	$10/$30/$50 Copays above apply	Copays above apply (after ded)	Not covered

This comparison is intended to illustrate plan benefits and should not be relied upon to fully determine benefits. Refer to carrier's EOCs for a complete representation of coverage terms and conditions.

[1] *Emergency copay waived if admitted to the hospital.*

[2] *Diagnostic Lab & Xray performed in a non-hospital setting are covered at no cost to the member.*

[3] *Outpatient hospital benefit limited to $350/admit when accessing care from a non-participating provider.*

[4] *Physical therapy, physical medicine & occupational therapy, including chiropractic services imited to 24 visits per calendar year.*

[5] *Up to 100 home health care visits per accumulation period*

[6] *Rehabilitation therapy (Physical, Occupational or Speech Therapy) when performed in a non-hospital based facility limited to a 60-day period of care.*

[7] *Home Health Care limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less.*