

	Current	Current	Current
Effective Date	01/01/2024	01/01/2024	01/01/2024
Carrier	<b>Kaiser Permanente</b>	<b>Sutter Health Plus</b>	<b>WHA</b>
Plan Name	HMO - \$30	HMO - \$30	HMO - \$30
Benefit Summary	Active & Early Retiree	Active & Early Retiree	Active & Early Retiree
<b>General Plan Information</b>			
Annual Deductible/Individual	\$0	\$0	\$0
Annual Deductible/Family	\$0	\$0	\$0
Coinsurance	100%	100%	100%
Office Visit/Exam	\$30 copay	\$30 copay	\$30 copay
Outpatient Specialist Visit	\$30 copay	\$30 copay	\$30 copay
Annual Out-of-Pocket Limit/Individual	\$1,500	\$1,500	\$1,500
Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000	\$2,500
Deductible Included in Out-of-Pocket Limits	N/A	N/A	N/A
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes
<b>Outpatient Services</b>			
<b>Preventive Services</b>			
Well-Child Care	100%	100%	100%
Immunizations	100%	100%	100%
Well Woman Exams	100%	100%	100%
Adult Periodic Exams with Preventive Tests	100% if preventive 100%	100%	100% if preventive 100%
EGUSD Annual Wellness Exam	Covered once per Calendar Year	Covered once per Calendar Year	Covered once per Calendar Year
Diagnostic X-Ray and Lab Tests	\$10 copay per encounter; 100% if preventive; \$50 copay per procedure: MRI, CT and PET scans	100%	100%
<b>Maternity Care</b>			
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100%
<b>Inpatient Hospital Services</b>			
Inpatient Hospitalization	100%	100%	100%
Pre-Authorization of Services Required	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	100%	100%
<b>Surgical Services</b>			
Outpatient Facility Charge	\$30 copay per procedure	\$30 copay in an office setting; \$100 copay if performed in a surgical center	\$100 copay per visit
<b>Emergency Services</b>			
Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
<b>Ambulance</b>			
Air	100%	100%	100%
Ground	100%	100%	100%
<b>Urgent Care</b>			
Urgent Care Facility	\$30 copay	\$30 copay	\$30 copay
<b>Mental Health Benefits</b>			
Inpatient Care	100%	100%	100%
Outpatient Care	\$30 copay individual therapy; \$15 copay group therapy	\$30 copay for individual therapy; \$15 copay for group therapy	\$30 copay
<b>Substance Abuse</b>			
<b>Inpatient Care</b>			
Inpatient Hospitalization	100%	100%	100%
Inpatient Detoxification Services	100%	100%	100%
<b>Outpatient Care</b>			
Outpatient Services	\$30 copay individual therapy; \$5 copay group therapy	\$30 copay	\$30 copay

	Current	Current	Current
<b>Effective Date</b>	01/01/2024	01/01/2024	01/01/2024
<b>Carrier</b>	<b>Kaiser Permanente</b>	<b>Sutter Health Plus</b>	<b>WHA</b>
<b>Plan Name</b>	HMO - \$30	HMO - \$30	HMO - \$30
<b>Benefit Summary</b>	Active & Early Retiree	Active & Early Retiree	Active & Early Retiree
<b>Prescription Drug Benefits</b>			
Prescription Drug Deductible	\$0	\$0	\$0
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
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
Generic	\$15 copay (Tier 1)	\$15 copay (Tier 1)	\$10 copay (Tier 1)
Brand (Formulary/Preferred)	\$35 copay (Tier 2)	\$25 copay (Tier 2)	\$30 copay (Tier 2)
Brand (Non-Formulary/Non-preferred)	\$35 copay (Tier 3)	\$50 copay (Tier 3)	\$50 copay (Tier 3)
Specialty	\$35 copay (Tier 4)	10% coinsurance up to \$100 per Rx	\$35 copay; home self-injectables
Number of Days Supply	30 days	30 days	30 days
<b>Mail Order</b>			
Generic	\$30 copay (Tier 1)	\$30 copay (Tier 1)	\$20 copay (Tier 1)
Brand (Formulary/Preferred)	\$70 copay (Tier 2)	\$50 copay (Tier 2)	\$60 copay (Tier 2)
Brand (Non-Formulary/Non-preferred)	\$70 copay (Tier 3)	\$100 copay (Tier 3)	\$100 copay (Tier 3)
Number of Days Supply for Mail Order	100 days	100 days	90 days
<b>Other Services and Supplies</b>			
Durable Medical Equipment & Prosthetic Devices	100%	100%	100%
Home Health Care	100% 100 visits per cal year	100%; Limited to 100 visits per cal year	100% 100 visits per cal year
Skilled Nursing or Extended Care Facility	100% 100 days per benefit period	100%; Limited to 100 days per cal year	100% 100 days per benefit period
Hospice Care	100%	100%	100%
Chiropractic Services	Not covered	\$15 copay; Limited to 20 visits per cal year combined with Acupuncture	\$15 copay; 20 visits per cal year
Acupuncture	Must be referred	\$15 copay; Limited to 20 visits per cal year combined with Chiropractic	\$15 copay; 20 visits per cal year
<b>Vision</b>			
Examination	\$30 copay: refraction	100% covered for preventive screening	100%
<b>Hearing</b>			
Screening	100%	100% through TruHearing (\$50 copay out-of-network)	100% from PCP; No cost hearing exam from TruHearing
Aid(s)	\$1,000 allowance per aid every 36 months	\$1,000 allowance every 60 months per aid for adult/ 24 months for children	\$1,000 allowance max amount plan will pay per member every 36 months for both ears
<b>Infertility</b>			
Diagnosis	See Plan Certificate	See Plan Certificate	See Plan Certificate
Treatment	See Plan Certificate	See Plan Certificate	See Plan Certificate
<b>Outpatient Rehabilitative Therapy Services</b>			
Physical	\$30 copay	\$30 copay	\$30 copay
Occupational	\$30 copay	\$30 copay	\$30 copay
Speech	\$30 copay	\$30 copay	\$30 copay