non-Medicare plans

generally for those **under age 65**

IMPORTANT NOTES		Health Net HMO **1.800.522.0088** Group 57358-A **www.healthnet.com**
SDCERA-sponsored medical plans do not have overall annual or lifetime limits. Service area varies by plan. Please confirm you live within a plan's service area before enrolling. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern.		**HMO plan** You are required to use the primary care physician you select from a list of providers.
Annual deductible	Any applicable deductible must be met before coverage shown is effective.	None
Ambulance	Requires preauthorization.	Covered in full
Anesthesia		Covered in full
Chiropractic visit	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Preauthorization may be required.	Not covered
Durable medical equipment		Covered in full
Emergency care	Includes accidental injury and acute illness; the copayment shown is when visiting an emergency room and is waived if you are admitted.	$35
Fitness club membership		Discounts available
Hearing care and hearing aids		Preventive screening covered in full; all other $20 per exam. No coverage for hearing aids.
Home health care	Requires a physician's prescription.	Covered in full up to 30 days; $10 copayment starts on the 31st day after the 1st visit.
Hospice care		Covered in full
Hospital room and board	Coverage is for a semi-private room.	Covered in full
Laboratory fees		Covered in full
Physician care (doctor visits) unrelated to hospitalization	The copayments shown are for office visits unrelated to hospitalization.	$20 per office visit
Physician care (doctor visits) due to hospitalization	Coverage shown is for visits due to hospitalization.	Covered in full
Prescription medications from a mail order sponsored by the carrier	The copayments in all cases are for the number of days shown.	$20 generic, $60 brand name, $90 non-formulary. *90-day supply.*
Prescription medications from a pharmacy	Unless noted, non-formulary prescriptions are covered by the same copayments when deemed medically necessary.	$10 generic, $30 brand name, $45 non-formulary. *30-day supply.*
Psychiatric care (inpatient)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full No limit on days
Psychiatric care (outpatient)		$20 per visit, unlimited visits
Rehabilitation therapy	Physical, speech, occupational, pulmonary, and cardiac	Covered in full
Skilled nursing facility		Covered in full up to 100 days
Surgery (inpatient)		Covered in full
Surgery (outpatient)		Covered in full
Urgent care	An asterisk (*) indicates non-emergency.	$35
Vision care and eyewear		$20 per exam; No coverage for eyewear.
X-rays		Covered in full
Monthly premium per person		$1,389.08

Kaiser Permanente HMO	UHC Signature Value HMO
1.800.464.4000 Group 104302 **www.kp.org**	**1.800.624.8822** Group 004501 **www.myuhc.com**
HMO plan	**HMO plan**
You are required to use Kaiser Permanente physicians and facilities. A higher premium will apply if you enroll in this plan when eligible for Medicare.	You are required to use the primary care physician you select from a list of providers.
None	None
Covered in full	Covered in full
Covered in full	Covered in full
$10 per visit, up to 20 visits	$15 per visit, up to 20 visits.
Covered in full	Covered in full
$25	$50
Discounts available	Discounts available
Preventive screening covered in full; All other $20 per exam. No coverage for hearing aids.	$20 per exam; Hearing aids are covered in full up to $5,000 every 36 months.
Covered in full up to 100 days	Covered in full up to 100 visits per year
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
$20 per office visit	$20 per office visit
Covered in full	Covered in full
$15 generic, $30 brand name. *Up to a 100-day supply.*	$30 generic, $60 brand name. *90-day supply.*
$15 generic, $30 brand name. *Up to a 100-day supply. Specialty drugs up to 30 days.*	$15 generic, $30 brand name. *30-day supply.*
*Covered in full Unlimited visits	*Covered in full No limit on days
$20 per visit, unlimited visits	$20 per visit, unlimited visits
$0 inpatient, $20 per visit outpatient	$20 copay
Covered in full up to 100 days	Covered in full up to 100 consecutive calendar days from first treatment
Covered in full	Covered in full
$20 copayment	Covered in full
$20*	$50
No charge for routine eye exams with a plan optometrist. $20/exam. No coverage for eyewear.	$20 per exam; No coverage for eyewear.
Covered in full	Covered in full
$837.54	$1,733.87