

# 2018 NON-MEDICARE PLANS

## non-Medicare plans

generally for those under age 65

These plans are only available in the state of California.

**Health Net HMO**

**1.800.522.0088**

Group 57358-A

[www.healthnet.com](http://www.healthnet.com)

### IMPORTANT NOTES

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.

### Monthly premium per person

**\$1,510.19**

<b>Annual deductible</b>	Any applicable deductible must be met before coverage shown is effective.	None
<b>Ambulance</b>	Requires preauthorization.	Covered in full
<b>Anesthesia</b>		Covered in full
<b>Chiropractic visit</b>	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Preauthorization may be required.	Not covered
<b>Durable medical equipment</b>		Covered in full
<b>Emergency care</b>	Includes accidental injury and acute illness; the copayment shown is when visiting an emergency room and is waived if you are admitted.	\$35
<b>Fitness club membership</b>		Discounts available
<b>Hearing care and hearing aids</b>		Preventive screening covered in full; all other \$20 per exam. No coverage for hearing aids.
<b>Home health care</b>	Requires a physician's prescription.	Covered in full up to 30 days; \$10 copayment starts on the 31st day after the 1st visit.
<b>Hospice care</b>		Covered in full
<b>Hospital room and board</b>	Coverage is for a semi-private room.	Covered in full
<b>Laboratory fees</b>		Covered in full
<b>Physician care (doctor visits) unrelated to hospitalization</b>	The copayments shown are for office visits unrelated to hospitalization.	\$20 per office visit
<b>Physician care (doctor visits) due to hospitalization</b>	Coverage shown is for visits due to hospitalization.	Covered in full
<b>Prescription medications from a mail order sponsored by the carrier</b>	The copayments in all cases are for the number of days shown.	\$20 generic, \$60 brand name, \$90 non-formulary. <i>90-day supply.</i>
<b>Prescription medications from a pharmacy</b>	Unless noted, non-formulary prescriptions are covered by the same copayments when deemed medically necessary.	\$10 generic, \$30 brand name, \$45 non-formulary. <i>30-day supply.</i>
<b>Psychiatric care (inpatient)</b>	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
<b>Psychiatric care (outpatient)</b>		\$20 per visit, unlimited visits
<b>Rehabilitation therapy</b>	Physical, speech, occupational, pulmonary, and cardiac	Covered in full
<b>Skilled nursing facility</b>		Covered in full up to 100 days
<b>Surgery (inpatient)</b>		Covered in full
<b>Surgery (outpatient)</b>		Covered in full
<b>Urgent care</b>	An asterisk (*) indicates non-emergency.	\$35
<b>Vision care and eyewear</b>		\$20 per exam; No coverage for eyewear.
<b>X-rays</b>		Covered in full

<b>Kaiser Permanente HMO</b>	<b>UHC Signature Value HMO</b>
<b>1.800.464.4000</b> Group 104302 <b>www.kp.org</b>	<b>1.800.624.8822</b> Group 004501 <b>www.myuhc.com</b>
<b>HMO plan</b>	<b>HMO plan</b>
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.
<b>\$859.09</b>	<b>\$2,334.18</b>
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. <i>Up to a 100-day supply.</i>	\$30 generic, \$60 brand name. <i>90-day supply.</i>
\$15 generic, \$30 brand name. <i>Up to a 100-day supply. Specialty drugs up to 30 days.</i>	\$15 generic, \$30 brand name. <i>30-day supply.</i>
*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 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.	\$20 per exam; No coverage for eyewear.
Covered in full	Covered in full