2022–2023 San Joaquin County Medical Plan Comparison Grid

	Select and Select Exclusive (SE)	Premier	Kaiser HMO	Sutter Health Plus (SHP) HMO*	Kaiser HDHP**	Sutter Health Plus (SHP) HDHP**
PLAN PROVISIONS AND PARTICIPANT SHARE OF COST UNDER EACH PLAN						
Plan Providers "SJGH" refers to San Joaquin General Hospital	**Select:** Providers in Anthem Prudent Buyer network, 3 counties only: • San Joaquin • Sacramento • Stanislaus **SE:** SJGH providers only	Providers in the Anthem Prudent Buyer (California) and National BlueCard PPO (outside California) networks	Kaiser facilities and physicians only	SHP-contracted facilities and physicians only	Kaiser facilities and physicians only	SHP-contracted facilities and physicians only
Deductibles	$250 per person $500 per family ($125/$250 if using SJGH)	$125 per person $250 per family	None	None	$1,500 Single $2,800 Individual in Family $3,000 Family	$1,500 Single $2,800 Individual in Family $3,000 Family
Out-of-Pocket Maximum	$1,000 per person $2,500 per family Separate maximums for Medical and Prescription Drug	$1,000 per person $2,500 per family Separate maximums for Medical and Prescription Drug	$1,500 per person $3,000 per family	$1,500 per person $3,000 per family	$3,000 Single $3,000 Individual in Family $6,000 Family	$3,000 Single $3,000 Individual in Family $6,000 Family
Acupuncture & Chiropractic (Up to 20 total visits per year combined, if plan choice covers the benefit)	Plan pays up to $25 per visit after deductible Does not apply to out-of-pocket maximum	Plan pays up to $25 per visit after deductible Does not apply to out-of-pocket maximum	Not covered Discounts available – contact Kaiser for information	$20 copay per visit No referral needed	Not covered Discounts available – contact Kaiser for information	**Acupuncture:** 10% coinsurance after deductible, PCP referral required (limited to treatment of nausea or as part of a comprehensive pain management program addressing chronic pain) **Chiropractic:** Not covered
Ambulance	No charge after deductible	No charge after deductible	No charge	No charge	10% coinsurance after deductible	No charge after deductible

**Not available to non-CRNA employees in Unit X*
***Not available to Sheriff's Deputies and non-CRNA employees in Unit X*

	Select and Select Exclusive (SE)	Premier	Kaiser HMO	Sutter Health Plus (SHP) HMO*	Kaiser HDHP**	Sutter Health Plus (SHP) HDHP**
PLAN PROVISIONS AND PARTICIPANT SHARE OF COST UNDER EACH PLAN						
Doctor Visits Specialists Allergy testing/ treatment	$10 copay per visit $5 copay per visit for SJGH *Deductible does not apply*	$5 copay per visit *Deductible does not apply*	$10 copay per visit	$10 copay per visit	10% coinsurance after deductible	10% coinsurance after deductible
Durable Medical Equipment	50% of charges after deductible	50% of charges after deductible	20% of charges	No charge	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room (Hospital facility charge waived if admitted)	$100 copay per admission after deductible $40 copay for SJGH	$100 copay per admission after deductible	$100 per visit	$50 per visit	10% coinsurance after deductible	10% coinsurance after deductible
Home Health Care	No charge after deductible	No charge after deductible	No charge	No charge, up to 100 visits per calendar year	No charge after deductible	No charge after deductible, up to 100 visits per calendar year
Hospice	No charge after deductible	No charge after deductible	No charge	No charge	No charge after deductible	No charge after deductible
Hospital Inpatient or Intensive Care Unit (ICU)	**SJGH Facility:** No charge after deductible **Other Facility:** $100 copay per admission after deductible **Physician/ Surgeon fees:** No charge after deductible	**Facility:** $100 copay per admission after deductible **Physician/ Surgeon fees:** No charge after deductible	No charge	No charge	10% coinsurance after deductible	10% coinsurance after deductible
Hospital Outpatient Surgery	**Facility and Surgeon fees:** No charge after deductible **Physician fees:** $5 copay per visit after deductible **SJGH Physician fees:** $10 copay per visit after deductible	**Facility and Surgeon fees:** No charge after deductible **Physician fees:** $5 copay per visit after deductible	$10 copay	$10 copay	10% coinsurance after deductible	10% coinsurance after deductible

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PLAN PROVISIONS AND PARTICIPANT SHARE OF COST UNDER EACH PLAN						
Laboratory Services	No charge after deductible	No charge after deductible	No charge	No charge	10% coinsurance after deductible	10% coinsurance after deductible
Prescription Drugs	**Up to 30 days:** $5 generic $15 preferred Non-preferred not covered	**Up to 30 days:** $5 generic $10 preferred $30 non-preferred	**Up to 100 days** $10 generic $20 preferred	**Up to 30 days:** $10 Tier 1 drugs $20 Tier 2 drugs $40 Tier 3 drugs $40 Tier 4 drugs	**Up to 30 days*:** $10 generic $30 preferred $60 specialty drugs	**Up to 30 days*:** $10 Tier 1 drugs $30 Tier 2 drugs $60 Tier 3 drugs 10% up to $100
	Up to 90 days: $10 generic $30 preferred Non-preferred not covered *Deductible does not apply*	**Up to 90 days:** $10 generic $20 preferred $60 non-preferred *Deductible does not apply*	**Up to 30 days <u>only</u>:** $20 specialty drugs	**Up to 100 days:** $20 Tier 1 drugs $40 Tier 2 drugs $80 Tier 3 drugs N/A Tier 4	**Up to 100 days** (mail-order only)*: $20 generic $60 preferred **after deductible*	**Up to 100 days*:** $20 Tier 1 drugs $60 Tier 2 drugs $120 Tier 3 drugs N/A Tier 4 **after deductible*
Preventive Care Services (Affordable Care Act Requirement)	No charge *Deductible does not apply*	No charge *Deductible does not apply*	No charge	No charge	No charge	No charge
Rehabilitation Therapy (Physical, Speech, and Occupational)	**Outpatient:** $10 copay per visit after deductible **Inpatient:** No charge after deductible	**Outpatient:** $5 copay per visit after deductible **Inpatient:** No charge after deductible	$10 copay per visit	$10 copay per visit	10% coinsurance after deductible	10% coinsurance after deductible
Urgent Care	$40 copay per visit after deductible	$40 copay per visit after deductible	$10 copay per visit	$10 copay per visit	10% coinsurance after deductible	10% coinsurance after deductible
X-Rays	No charge after deductible	No charge after deductible	No charge	No charge	10% coinsurance after deductible	10% coinsurance after deductible

This matrix is for cursory plan comparison only. Detailed benefit information is available in each plan's Plan Document.

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