**KAISER SENIOR ADVANTAGE**
**2020 COMPARISON OF GROUP PLANS VS. INDIVIDUAL PLANS**

| | SJUSD<br>Group Plan 205-266<br>Kaiser Senior Advantage HMO | SJUSD<br>Group Plan 205-267<br>Kaiser Senior Advantage HMO | Kaiser<br>Individual Plan 1 - Enhanced Plan<br>Kaiser Senior Advantage HMO | Kaiser<br>Individual Plan 2 - Basic Plan<br>Kaiser Senior Advantage HMO |
|---|---|---|---|---|
| **2020 Monthly Premium per Individual (excluding any Medicare Premiums)** | **$311.64** | **$268.66** | **$88.00** | **$24.00** |
| **BENEFITS AND COVERAGE** | **You Pay** | **You Pay** | **You Pay** | **You Pay** |
| **Out-of-Pocket Maximum**<br>Annual Out-of-Pocket Maximum per Individual | $1,500 | $1,500 | $5,400* | $6,700* |
| **Primary Care & Specialist office visits** | $15 | $25 | $20 Primary/$25 Specialist | $35 |
| **Emergency Department Services** | $50 | $50 | $90 | $90 |
| **Urgent Care** | $15 | $25 | $20 | $35 |
| **Ambulance Services** | $100 | $100 | $200 | $200 |
| **Inpatient Hospital Care** | $250 copay per admission | $250 copay per admission | Days 1-7: $265 per day<br>$0 for additional hospital days | Days 1-7: $285 per day<br>$0 for additional hospital days |
| **Skilled Nursing Facility**<br>(up to 100 days per benefit period) | $0 | $0 | Days 1-20: $0 per day<br>Days 21-100: $100 per day | Days 1-20: $0 per day<br>Days 21-100: $100 per day |
| **Home Healthcare Visits** | $0 | $0 | $0 | $0 |
| **Outpatient Services/Surgery** | $50 | $50 | $250 | $250 |
| **Outpatient X-ray Services** | $0 | $0 | $20 lab; $40 X-ray/ultrasound,<br>$190 MRI/PET/CT | $30 lab; $50 X-ray/ultrasound,<br>$215 MRI/PET/CT |
| **Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| **Mental Health Services** | | | | |
| Inpatient hospitalization | $250 copay per admission | $250 copay per admission | Days 1-7: $265 copay per day<br>$0 copay for additional hospital days | Days 1-7: $285 copay per day<br>$0 copay for additional hospital days |
| Outpatient visits | $15/individual visit; $7/group visit | $25/individual visit; $12/group visit | $20/individual visit; $10/group visit | $35/individual visit; $17/group visit |
| **Chemical Dependency Services** | | | | |
| Inpatient detoxification | $250 copay per admission | $250 copay per admission | Days 1-7: $265 per day<br>$0 for additional hospital days | Days 1-7: $285 per day<br>$0 for additional hospital days |
| Outpatient visits | $15/individual visit | $25/individual visit | $20/individual visit | $35/individual visit |
| **Hearing Aid Coverage** | Not Covered | Not Covered | Not Covered | Not Covered |

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| | **SJUSD**<br>**Group Plan 205-266**<br>**Kaiser Senior Advantage HMO** | **SJUSD**<br>**Group Plan 205-267**<br>**Kaiser Senior Advantage HMO** | **Kaiser**<br>**Individual Plan 1 - Enhanced Plan**<br>**Kaiser Senior Advantage HMO** | **Kaiser**<br>**Individual Plan 2 - Basic Plan**<br>**Kaiser Senior Advantage HMO** |
|---|---|---|---|---|
| **Outpatient Prescription Drugs** | | | | |
| **Initial Coverage**<br><br>**Retail Pharmacy** | Full Coverage when you pay the below copays. | Full Coverage when you pay the below copays. | You pay the below copays until total yearly drug costs reach **$4,020** | You pay the below copays until total yearly drug costs reach **$4,020** |
| Generic (preferred) | $10 copay for 100 day supply | $10 copay for 30 day supply | $5/$15 copay for 30 day supply | $6/$18 copay for 30 day supply |
| Brand (preferred) | $25 copay for 100 day supply | $25 copay for 30 day supply | $47/$100 copay for 30 day supply | $47/$100 copay for 30 day supply |
| Non-Preferred or Specialty | NA | NA | 33% coinsurance for 30 day supply | 33% coinsurance for 30 day supply |
| **Mail Order Pharmacy** | | | | |
| Generic (preferred) | $10 copay for 100 day supply | $20 copay for 100 day supply | $10/$30 copay for 100 day supply | $12/$36 copay for 100 day supply |
| Brand (preferred) | $25 copay for 100 day supply | $50 copay for 100 day supply | $94/$200 copay for 100 day supply | $94/$200 copay for 100 day supply |
| Non-Preferred or Specialty | NA | NA | 33% coinsurance for 100 day supply | 33% coinsurance for 100 day supply |
| **Gap Coverage** | Not Applicable (above copays apply) | Not Applicable (above copays apply) | **After your total yearly drug costs reach $4,020, you receive limited coverage by the plan on certain drugs.** You will pay the same copay for generics during this phase or 33% coinsurance, whichever is lower. For brand and specialty drugs you will pay 25% and a portion of the dispensing fee until your yearly out-of-pocket drug costs reach **$6,350.** | **After your total yearly drug costs reach $4,020, you receive limited coverage by the plan on certain drugs.** You will pay the same copay for generics during this phase or 33% coinsurance, whichever is lower. For brand and specialty drugs you will pay 25% and a portion of the dispensing fee until your yearly out-of-pocket drug costs reach **$6,350.** |
| **Catastrophic Coverage** | Not Applicable (above copays apply) | Not Applicable (above copays apply) | After reaching **$6,350**, you pay: | After reaching **$6,350**, you pay: |
| Generic | NA | NA | $3 copay | $3 copay |
| Brand | NA | NA | $12 copay | $12 copay |
| Specialty | NA | NA | $12 copay | $12 copay |

**Part D prescription drug costs under the Individual KPSA plan will **not** apply to the plan's annual Out of Pocket maximum.*

*Please note: This is only a summary of the benefits provided under the above named plans. This comparison does not provide complete details. Additional details can be found in the official plan documents. If there is any conflict between the information presented here and the official plan documents, the official plan documents will govern. For questions regarding the Individual Plan shown above, please contact Kaiser Permanente.*