

**San Juan Unified School District**  
**2020 Medical Renewal**  
**Post-65 Retiree HMO Plans**

	<b>Kaiser Options</b>		<b>United Healthcare Options</b>	
	<b>Group Plan 205-EU266 Kaiser Senior Advantage HMO</b>	<b>Group Plan 205-EU267 Kaiser Senior Advantage HMO</b>	<b>Group Medicare Advantage Plan United Healthcare</b>	<b>Senior Supplement United Healthcare</b>
<b>2019 Monthly Premium per Individual (excluding any Medicare Premiums or deductibles)</b>	<b>\$311.64</b>	<b>\$268.66</b>	<b>\$465.65</b>	<b>\$655.01</b>
<b>BENEFITS AND COVERAGE</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Out-of-Pocket Maximum</b>				
Annual Out-of-Pocket Maximum per Individual	\$1,500	\$1,500	\$2,000	\$0
<b>Primary Care/Specialist office visits</b>	\$15	\$25	\$10 PCP / \$20 Specialty	\$0
<b>Emergency Department Services</b>	\$50	\$50	\$50	\$0
<b>Urgent Care</b>	\$15	\$25	\$35	\$0
<b>Ambulance Services</b>	\$100	\$100	\$50	\$0
<b>Inpatient Hospital Care</b>	\$250 copay per admission	\$250 copay per admission	\$200 copay per admission	\$0
<b>Skilled Nursing Facility</b> (up to 100 days per benefit period)	\$0	\$0	\$0 copay day 1 to 20; \$50 copay days 21 to 100	\$0
<b>Home Healthcare Visits</b>	\$0	\$0	\$0	\$0
<b>Outpatient Services/Surgery</b>	\$50	\$50	\$100	\$0
<b>Outpatient X-ray Services</b>	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment</b>	20% coinsurance	20% coinsurance	20% Coinsurance	\$0
<b>Mental Health Services</b>				
Inpatient hospitalization	\$250 copay per admission	\$250 copay per admission	\$200 copay per admission	\$0
Outpatient visits	\$15/individual visit; \$7/group visit	\$25/individual visit; \$12/group visit	\$20/individual visit; \$10/group visit	\$0

## Post-65 Retiree HMO Plans

	Kaiser Options		United Healthcare Options	
	Group Plan 205-EU266 Kaiser Senior Advantage HMO	Group Plan 205-EU267 Kaiser Senior Advantage HMO	Group Medicare Advantage Plan United Healthcare	Senior Supplement United Healthcare
	You Pay	You Pay	You Pay	You Pay
<b>Chemical Dependency Services</b>				
Inpatient detoxification	\$250 copay per admission	\$250 copay per admission	\$200 copay per admission	\$0
Outpatient visits	\$15/individual visit; \$5/group visit	\$25/individual visit; \$5/group visit	\$20/individual visit; \$10/group visit	\$0
<b>Hearing Aid Coverage</b>	Not Covered	Not Covered	\$500 allowance every 36 months	\$500 allowance every 36 months
<b>Outpatient Prescription Drugs</b>				
<b>Initial Coverage</b>	Full Coverage when you pay the below copays.	Full Coverage when you pay the below copays.	Full Coverage when you pay the below copays.	Full Coverage when you pay the below copays.
<b>Retail Pharmacy</b>				
Generic (preferred)	\$10 copay for 100 day supply	\$10 copay for 30 day supply	\$10 copay for 31 day supply	\$10 copay for 31 day supply
Brand (preferred)	\$25 copay for 100 day supply	\$25 copay for 30 day supply	\$25 copay for 31 day supply	\$20 copay for 31 day supply
Non-Preferred or Specialty	NA	NA	\$50 copay for 31 day supply	\$35 copay for 31 day supply
<b>Mail Order Pharmacy</b>				
Generic (preferred)	\$10 copay for 100 day supply	\$20 copay for 100 day supply	\$20 copay for 90 day supply	\$20 copay for 90 day supply
Brand (preferred)	\$25 copay for 100 day supply	\$50 copay for 100 day supply	\$50 copay for 90 day supply	\$40 copay for 90 day supply
Non-Preferred or Specialty	NA	NA	\$100 copay for 90 day supply	\$70 copay for 90 day supply
<b>Gap Coverage</b>	Not Applicable (above copays apply)	Not Applicable (above copays apply)	Not Applicable (above copays apply)	Not Applicable (above copays apply)
<b>Catastrophic Coverage</b>	Not Applicable (above copays apply)	Not Applicable (above copays apply)	Not Applicable (above copays apply)	Not Applicable (above copays apply)