2009 San Diego Unified School District

Feature	Kaiser 5/5	PacifiCare HMO	PacifiCare POS	
			In-Network	**Out-of-Network**
Deductible	None	None	None	$250/individual $500/family
Maximum Benefit While Covered	Unlimited	Unlimited	Unlimited	$5,000,000
Annual Copayment Maximum	$1,500/individual $3,000/family	$800/individual $2,400/family	$1,000/individual $2,000/family	$7,500/individual $15,000/family
Emergency Care	$50 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Pre-Existing Conditions	All conditions covered provided they are covered benefits	All conditions covered provided they are covered benefits	All conditions covered provided they are covered benefits	All conditions covered provided they are covered benefits
Ambulance Services	No charge	No charge	No charge	No charge
Inpatient Hospital Care	No charge	No charge	$200/admission	50% coinsurance
Inpatient Physician Services	No charge	No charge	No charge	50% coinsurance
Office Visits	$5 copay	$5 copay	$10 copay	50% coinsurance
Outpatient Diagnostic Laboratory and Radiology	No charge	No charge	No charge	50% coinsurance
Outpatient Allergy Tests	$5 copay	$5 copay	$10 copay	50% coinsurance
Outpatient Surgery	$5 copay	No charge	No charge	50% coinsurance
Outpatient Physical/Rehabilitation Therapy	$5 copay	$5 copay	$10 copay	50% coinsurance *(up to 60 consecutive days from first treatment/condition)*
Routine Physical Exam	$5 copay	No charge	No charge	Children 2-17 years: 50% coinsurance Adults 18 years and over: not covered
Well-Woman Care	$5 copay	No charge	No charge	50% coinsurance
Maternity and Well-Baby Care	$5 copay	No charge $5 copay applies to infants who are ill at time of service; well-baby care is limited to children under age 2 See Schedule of Benefits for specific benefits and copays	Inpatient Maternity: $200 copay/admission Outpatient Maternity & Well-Baby Care: No charge $10 copay applies to infants who are ill at time of service; well-baby care is limited to children under age 2 See Schedule of Benefits for specific benefits/copays.	50% coinsurance. See Schedule of Benefits for specific benefits/copays
Family Planning *(special services require certain copayments and coinsurance)*	$5 copay	$5 copay	$10 copay	Not covered
Chiropractor Services	$10 copay, up to 30 visits/calendar year, covered through American Specialty Health; no referral required	$10 copay, up to 30 visits/calendar year, covered through American Speciality Health, no referral required	$10 copay, up to 30 visits/calendar year, covered through American Specialty Health, no referral required	Not covered
Hearing Screening	$5 copay	No charge	No charge	Not covered
Home Health Care	No charge (up to 100 two hour visits/calendar year; up to 3 visits/day)	No charge	No charge	50% coinsurance (up to 100 visits/year)
Skilled Nursing Care	No charge *(up to 100 days per benefit period)*	No charge (unlimited)	No charge (unlimited)	50% coinsurance (up to 60 consecutive days from the first treatment/disability)
Hospice Care	No charge	No charge (prognosis of life expectancy of one year or less)	No charge (prognosis of life expectancy of one year or less)	50% coinsurance (prognosis of life expectancy of one year or less)

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Prescription Drugs	(up to a 100-day supply) (50% coinsurance for up to a 100-day supply of drugs related to the treatment of sexual dysfunction disorders; episodic drugs are limited to 27 doses in any 100-day period)	Must use a participating Medco Health retail pharmacy or Medco By Mail. Member is responsible for the following copays:	Must use a participating Medco Health retail pharmacy or Medco By Mail. Member is responsible for the following copays:	The greater of: 50% of the cost, or $10 for generic/$35 for preferred brand/$65 for non-preferred; each prescription limited to 30-day supply.
	$5 copay	Medco retail pharmacy network (up to 30-day supply)	Medco retail pharmacy network (up to 30-day supply)	
	Mail order: $5 for a up to 100 day supply	Generic $5	Generic $5	Medco By Mail not available
		Preferred brand $10	Preferred brand $15	
		Non-preferred brand $25	Non-preferred brand $30	
		Medco By Mail (up to 90-day supply)	Medco By Mail (up to 90-day supply)	
		Generic $10	Generic $10	
		Preferred brand $20	Preferred brand $30	
		Non-preferred brand $50	Non-preferred brand $60	
		You may fill your prescription plus two refills at the retail pharmacy copay. On the fourth and subsequent refills, you pay the Medco By Mail copay whether you purchase a 30-day supply at a retail pharmacy or a 90-day supply through Medco By Mail. A generic drug will always be dispensed if one is available. If you purchase a brand name drug when a generic alternative is available, you will pay the generic drug copay plus the difference in cost between the brand name and generic drug, even if your doctor writes “dispense as written” on the prescription.	*You may fill your prescription plus two refills at the retail pharmacy copay. On the fourth and subsequent refills, you pay the Medco By Mail copay whether you purchase a 30-day supply at a retail pharmacy or a 90-day supply through Medco By Mail. A generic drug will always be dispensed if one is available. If you purchase a brand name drug when a generic alternative is available, you will pay the generic drug copay plus the difference in cost between the brand name and generic drug, even if your doctor writes “dispense as written” on the prescription.*	
Mental Health Services	Inpatient:	Preauthorization required through PacifiCare Behavioral Health, PCP referral not required	Inpatient: No charge after $200 copay/admit	Not covered
	Non-mental health parity: no charge, up to 45 days/calendar year	Inpatient: No charge, unlimited days	Outpatient: $10 copay/visit, unlimited visits	
	Mental health parity: no charge; no day limit	Outpatient: $5 copay/visit, unlimited visits		
	Outpatient: Non-mental health parity: $5 copay for individual visits; $2 copay for group visits; 20 individual and group visits/calendar year Mental health parity: $5 copay/visit; no visit limit			
Substance Abuse Services	Inpatient: Provided at no charge for detoxification	Preauthorization required through PacifiCare Behavioral Health, PCP referral not required	Preauthorization required through PacifiCare Behavioral Health, PCP referral not required	Not covered
		Inpatient: $25 copay/day, 30 day maximum	Inpatient: No charge after $250 copay/admit, 30 day maximum, 2 treatments/lifetime	
	Outpatient: $5 copay for individual visit; $2 copay for group therapy	Outpatient: visits 1-20: $0 copay; visits 21-40: $20 copay; visits 41-60; $25 copay	Outpatient: visits 1-5: $0 copay; visits 6 & up: $10 copay	
	Transitional residential recovery services: $100/admission			
Plan Availability	Available to all VEBA districts or associations	Available only to VEBA districts or associations in San Diego County	Available only to VEBA districts or associations in San Diego County	Available only to VEBA districts or associations in San Diego County
Disclaimer	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. See the Certificate/Evidence of Coverage for details.	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. See the Certificate/Evidence of Coverage for details	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. See the Certificate/Evidence of Coverage for details.	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. See the Certificate/Evidence of Coverage for details.