

City of Santa Rosa
Health Plan Comparison for 2012

NAME OF PLAN	Kaiser HMO	City PPO		City EPO
	Network Only	Participating Provider	Non-Participating Provider	Participating Provider Only
Employee Portion of Premium	12.5% 13.5% (Units 4, 6 & 7)*	12.5% 13.5% (Units 4, 6 & 7)*		20%**
Type of Plan/Service Area	HMO / Limited Service Area	Preferred Provider Organization / Any Service Area		Exclusive Provider Organization / California only
Access to Specialists	Must have PCP/ may refer yourself to some specialists within Kaiser	Can choose directly		Provider Referral or Self Referral
Network	Only when referred by Kaiser	BlueCross Prudent Buyer PPO	Available at higher cost	BlueCross Prudent Buyer PPO
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Pre-existing Condition Exclusion	No	No		No
Deductible Per Person	None	\$300		None
Deductible Per Family	None	\$900 (3 per family)		None
Out of Pocket Maximum Per Person *	\$1,500	\$1,500	Not Applicable	\$1,500
Out of Pocket Maximum Per Family *	\$3,000	\$3,000	Not Applicable	\$3,000
Prescription Drug Benefit	KAISER	MEDCO		MEDCO
30 day supply	\$10 generic 50% co-payment for drugs to treat sexual dysfunction	\$5 generic/\$20 brand/\$50 non-formulary Brand \$20 plus difference in cost over generic if generic readily available. Medically necessary only. 50% co-payment for drugs to treat sexual dysfunction		\$10 generic/\$25 brand ¹ /\$55 non-formulary - if medically necessary (plus difference in cost over generic if generic readily available) 50% co-payment for drugs to treat sexual dysfunction
Mail Order 90 days	\$10 generic 50% co-payment for drugs to treat sexual dysfunction	\$10/\$35/\$85 50% co-payment for drugs to treat sexual dysfunction		\$20/45/\$95 50% co-payment for drugs to treat sexual dysfunction
NOTE	N/A	All percentages are based on allowances under plan benefit - provider has agreed to accept allowable charge.	All percentages are of usual and customary charges - any charges above that are the responsibility of the employee.	N/A
Preventive Care: ob/gyn w/pap, mammograms, colonoscopy (PPO/EPO) ⁵ , prostate screenings, and physicals PER SCHEDULE. Well baby and prenatal visits.	\$0 co-pay per visit (well-baby, prenatal)	\$0 copay per visit/ 100% other (per schedule)	40%	\$0 copay
Physician Office Visits (for everything except preventive services) - mental health is paid the same as physical health	\$20 co-pay	\$20 copay	40%	\$25 co-payment per visit
Lab & X-Ray (Diagnostic)	No Copay	20%	40%	\$25 copay
Emergency Services	\$75 co-payment per visit (Waived if admitted)	\$75 per visit for ER (Waived if admitted)	40%	\$75 per visit for ER (Waived if admitted)
Ambulance	\$50 per trip	20%	40%	\$50 per trip
In Patient Hospital Services (includes room & board) and Physician Services	\$100 per admission	20% for up to 120 days	40%	250 per admission

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Out Patient Surgery Hospital	\$20 per procedure	20%	40%	\$250 per admission
Skilled Nursing Facility	No Charge - up to 100 days per plan year	20% Up to 60 days per confinement	40% Up to 60 days per confinement	\$250 per admission- 100 days maximum per calendar year
Home Health Care	No Charge - up to 100 visits	20% Up to 60 days per year	20% Up to 60 days per year	No charge for the first 30 days \$25 co-pay starting with 31st calendar day after 1st visit (up to 60 days per year)
Physical, Speech and Occupational Therapy	\$20 co-payment per visit for short-term physical, speech and occupational when prescribed by a Kaiser physician and when significant improvement is expected within 2 months	20%	40%	Inpatient or Outpatient - \$25 copay
Maternity Coverage	%0 co-payment for prenatal visits \$100 hospital charge	Prenatal - \$0 office visit co-pay hospitalization - 20% / 80% ¹	40%	\$0 co-payment for prenatal visits \$250 hospital admission co-payment
Family Planning /infertility	\$20 co-payment per visit (diagnosis & limited treatment per schedule)	Not Covered	Not Covered	Not Covered
Chiropractic/Acupuncture	Not Covered (Discounts Available)	20% Up to 20 visits per year for combined services.	40% Up to 20 visits per year for combined services.	Not Covered
Vision	\$20 co-pay per visit including routine eye exam (Eyeware not included)	20% Disease and accident only	40% Disease and accident only	\$25 co-pay Disease and Accident Only
Retiree Conversion	Yes (California only)	Yes		Yes (California only)
*OOP Max Includes	Medical Copays only - NOT RX	Med Copays & Coinsurance In Network - NOT RX	Out of network excluded from OOP Max	Medical Copays only - NOT RX

*PPO - 13.5% Premium Paid by Employees in Units 4, 6 & 7 (SRCEA)

**EPO PLAN IS NOT AVAILABLE TO EMPLOYEES IN UNITS 4, 6 & 7 (SRCEA)