San Joaquin Delta College Health Plans - 2009 / 2010

Available Plan Selections for Management/Confidential/Trustee

BENEFIT	KAISER HMO		PACIFICARE HMO	BLUE CROSS – PRUDENT BUYER PPO				
	Plan 1	Plan 7	Plan 1U	Plan 4A	Plan 5B	Plan 6B	Plan 8C	Plan 12
MAJOR MEDICAL*	**Out-of-Pocket Maximum**: $1500 individual $3000 family	**Out-of-Pocket Maximum**: $1500 individual $3000 family	**Out-of-Pocket Maximum**: $800 individual $2400 family	**Deductible:** $100 Ind / $300 Family **Coinsurance**: 90/10 **Out-of-Pocket Maximum**: $300 per person + deductible	**Deductible:** $100 Ind / $300 Family **Coinsurance**: 90/10 **Out-of-Pocket Maximum**: $300 per person + deductible	**Deductible:** $250 Ind / $750 Family **Coinsurance**: 80/20 **Out-of-Pocket Maximum**: $1000 per person + deductible	**Deductible:** $500 Ind / $1500 Family **Coinsurance**: 80/20 **Out-of-Pocket Maximum**: $2000 per person + deductible	**Deductible:** $2000 Ind / $6000 Family **Coinsurance**: 80/20 **Out-of-Pocket Maximum**: Ind: $5250 Fam: $10500
LIFETIME MAX PER PERSON	No Lifetime Maximum	No Lifetime Maximum	No Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
DOCTOR VISITS	Covered, No Charge	Covered, $25.00 Co-pay	Covered, No Charge	$10 Co-pay (Co-pay not applied to deductible or out-of-pocket max)	$20 Co-pay (Co-pay not applied to deductible or out-of-pocket max)	$10 Co-pay (Co-pay not applied to deductible or out-of-pocket max)	Major Medical*	Major Medical*
ANNUAL PHYSICAL	Covered, No Charge	Covered, $25.00 Co-pay	Covered, No Charge	Up to $200/year for emp& spouse bal to major med	Up to $200/year for emp& spouse bal to major med	Up to $200/year for emp& spouse bal to major med	Up to $200/year for emp& spouse bal to major med	Up to $200/year for emp& spouse bal to major med
IMMUNIZATIONS	Covered, No Charge	Covered, No Charge	Covered, No Charge	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical*
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge	Covered, No Charge up to Age 2, $25 Co-pay after Age 2	Covered, No Charge	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Covered, No Charge	Pap Smear, $25 Mammogram - No Charge	Covered, No Charge	Major Medical*	Major Medical*	Major Medical*	Major Medical*	Major Medical*
OUTPATIENT X-RAY & LAB	Covered, No Charge	Covered, No Charge	Covered, No Charge	Major Medical*	Major Medical*	Major Medical*	Major Medical*	Major Medical*

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PHYSICAL THERAPY	Covered, No Charge	Covered, $25.00 Co-pay	Covered, No Charge	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* Non-Par Providers limited to comb 13 visits per year, max $25 per visit.
INFERTILITY	Covered. No Charge	Covered at 50% of Cost	Covered at 50% of Cost	Not Covered w/BX - $7500 lifetime presc	Not Covered w/BX - $7500 lifetime presc	Not Covered w/BX - $7500 lifetime presc	Not Covered w/BX - $7500 lifetime presc	Not Covered w/BX - $7500 lifetime presc
CHIROPRACTIC	Not Covered	Not Covered	Not Covered	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* Non-Par Providers limited to comb 13 visits per year, max $25 per visit.	Major Medical* Non-Par Providers limited to comb 13 visits per year, max $25 per visit.
ACUPUNCTURE	Covered. No Charge referral by Plan Physician	Covered. $25 Co-pay referral by Plan Physician	Not Covered	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* Maximum of 12 visits per calendar year	Major Medical* Maximum of 12 visits per calendar year
HOSPITAL INPATIENT	Covered, No Charge	Covered, $250.00 Co-pay	Covered, No Charge	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room
HOSPITAL EMERGENCY ROOM	Covered, No Charge	Covered, $100.00 Co-pay Waived if Admitted	Outpatient Covered, No Charge/ ER $35.00 Co-pay	$35 Co-pay Major Medical* (Co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	$35 Co-pay Major Medical* (Co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	$35 Co-pay Major Medical* (Co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	$35 Co-pay Major Medical* (Co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	Major Medical*

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BENEFIT	KAISER HMO		PACIFICARE HMO	BLUE CROSS – PRUDENT BUYER PPO				
	Plan 1	Plan 7	Plan 1U	Plan 4A	Plan 5B	Plan 6B	Plan 8C	Plan 12
RADIATION, CHEMO, & SURGERY	Covered, No Charge	Inpatient: Covered, No Charge Outpatient: $50 Co-pay	Covered, No Charge	Major Medical*	Major Medical*	Major Medical*	Major Medical*	Major Medical*
HOME HEALTH CARE	Covered. No Charge (Limits)	Covered. No Charge (Limits)	Covered, No Charge	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year
HOSPICE	Covered. No Charge	Covered. No Charge	Covered, No Charge (prog. of life expectancy of one yr or less)	100% of Covered Expense with a lifetime max of $10,000	100% of Covered Expense with a lifetime max of $10,000	100% of Covered Expense with a lifetime max of $10,000	100% of Covered Expense with a lifetime max of $10,000	Major Medical* with lifetime maximum of $10,000
DURABLE MEDICAL EQUIPMENT	Covered. No Charge in accord with DME Formulary	Covered, 20% Coinsurance in accord with DME Formulary	Covered, No Charge	Major Medical*	Major Medical*	Major Medical*	Major Medical*	Major Medical*
AMBULANCE-GROUND/AIR	Covered. No Charge when medically necessary	Covered, $100 per trip	Covered. No Charge when medically necessary	Major Medical*	Major Medical*	Major Medical*	Major Medical*	Major Medical*
MENTAL HEALTH INPATIENT	Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity	Covered, $250 per admission 30-days per calendar year (limits) No limits with AB88 Parity	30 days per calendar year	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.
MENTAL HEALTH & SUBSTANCE ABUSE	**Outpatient** Covered, No Charge; 20 visits per calendar year No limits with AB88 Parity	**Outpatient** Covered, $25 Co-pay; 20 visits per calendar year No limits with AB88 Parity	Substance abuse limited to hospital detox plus residential treatment (limits)	After deductible met, 50% up to a maximum of $50 per visit to Preferred Providers & up to $25 to Non-Par Providers.	After deductible met, 50% up to a maximum of $50 per visit to Preferred Providers & up to $25 to Non-Par Providers.	After deductible met, 50% up to a maximum of $50 per visit to Preferred Providers & up to $25 to Non-Par Providers.	After deductible met, 50% up to a maximum of $50 per visit to Preferred Providers & up to $25 to Non-Par Providers.	After deductible met, 50% up to a maximum of $50 per visit to Preferred Providers & up to $25 to Non-Par Providers.

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SUBSTANCE ABUSE OUTPATIENT	Covered, No Charge for individual visits; No Charge for group visits (no limits)	Covered, $25 Co-pay for individual visits; $5.00 for group visits (no limits)		(Substance Abuse Limited to 50 Visits Per Year)	(Substance Abuse Limited to 50 Visits Per Year)	(Substance Abuse Limited to 50 Visits Per Year)	(Substance Abuse Limited to 50 Visits Per Year)	(Substance Abuse Limited to 50 Visits Per Year)
SUBSTANCE ABUSE INPATIENT	Detox- No Charge Transitional Res Recovery Service - $100 per admission (limits) Res. Rehab (30 days cal yr) - No Charge (limits)	Detox - $250 per admission Transitional Reidential Recovery Services - $100 per admission (limits)	Substance abuse limited to hospital detox plus residential treatment (limits)	$300 Co-pay – After Co-pay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	$300 Co-pay – After Co-pay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	$300 Co-pay – After Co-pay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	$300 Co-pay – After Co-pay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	After deductible met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime
PRESCRIPTION DRUGS	$5.00 Co-pay	$10.00 Generic $30.00 Brand	$5.00 Co-pay	$5.00 Generic $12.00 Brand⁺ (30-day supply)	$7.00 Generic $15.00 Brand⁺ $30.00 Premium⁺	$7.00 Generic $15.00 Brand⁺ $30.00 Premium⁺	$7.00 Generic $25.00 Brand⁺ $40.00 Premium⁺	Major Medical*
MAIL ORDER PRESCRIPTION DRUGS	$5.00 Co-pay	$20.00 Generic $60.00 Brand	$5.00 Co-pay	$10.00 Generic $18.00 Brand⁺ (90-day supply)	$15.00 Generic $35.00 Brand⁺ $70.00 Premium⁺	$15.00 Generic $35.00 Brand⁺ $70.00 Premium⁺	$15.00 Generic $60.00 Brand⁺ $90.00 Premium⁺	Major Medical*

Under Kaiser - Vision exam covered at cost of plan co-pay

** If a generic drug is available you must utilize the generic. if you elect the brand drug even when recommend by your doctor, you will be responsible for the difference in the cost of the brand drug plus the generic co-pay.*

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