Moraga School District

2024 HMO Plans/Rates

Carrier	Kaiser Permanente			Sutter Health Plus		United HealthCare	
Plan Name	HMO $5 copay/ $250 Admit	HMO $15 copay $1500/$3000	DHMO $20 copay/$500 Ded	HMO ML81 $20 OV Copay	DHMO ML88 $20 OV Copay $2500 Deductible/20%	Signature Value Harmony HMO 15/0%	Signature Value Harmony HMO 20/500A
General Plan Information							
Annual Deductible/Individual	$0	$0	$500	$0	$2,500	$0	$0
Annual Deductible/Family	$0	$0	$1,000	$0	$5,000	$0	$0
Coinsurance	100%	100%	90%	100%	20%	100%	100%
PCP/Specialist Office Visit/Exam	$5 copay	$15 copay	$20 copay	$20 copay	$20 copay	$15 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$1,500	$3,000	$1,500	$5,000	$1,500	$2,500
Annual Out-of-Pocket Limit/Family	$3,000	$3,000	$6,000	$3,000	$10,000	$3,000	$5,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Deductible Included in Out-of-Pocket Limits	Not Applicable	Not Applicable	Yes	Not Applicable	Yes	Not Applicable	Yes
Outpatient Services							
Preventive Services							
Well-Child Care	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Immunizations	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Well Woman/Mammogram Exams	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Hearing/Vision Exams	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Adult Periodic Exams with Preventive Tests	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
X-Ray/ Lab Tests - Non-Preventive	$0 copay	$0 copay	$10 copay	Lab: $20 copay X-ray: $0 copay	$20 copay	$0 copay	$0 copay
Outpatient Rehabilitative Therapy	$5 copay	$15 copay	$20 copay	$20 copay	$20 copay	$15 copay	$20 copay
Maternity Care							
Pregnancy and Maternity Care (Pre-Natal Care)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Inpatient Hospital Services							
Inpatient Care (Facility & Physician Fees)	$250 copay per admission	$250 copay per admission	10% after deductible	$250 copay per admission	20% coinsurance after deductible	$0 copay	$500 copay per admission
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surgical Services							
Outpatient Facility Charge	$5 copay per procedure	$15 copay per procedure	10% after deductible	$100 copay	20% coinsurance after deductible	$0 copay	$100 copay
Emergency Services							
Emergency Room (Waived if admitted)	$35 copay	$35 copay	10% after deductible	$100/visit	20% coinsurance after deductible	$50 copay	$100 copay
Ambulance - Ground/Air	100%	100%	$150 per trip	$50/trip	$0 copay after deductible	$50 copay	$100 copay
Urgent Care							
Urgent Care Facility	$250 copay per admission	$250 copay per admission	10% after deductible	$20 copay	$20 copay	$15 copay	$20 copay
Mental Health/Substance Abuse Benefits							
Inpatient Care (Facility & Physician Fees)	$5 Copay Individual; $2 copay Group	$15 Copay Individual; $7 Copay Group	$20 copay Individual; $10 copay Group	$250 copay per admission	20% coinsurance after deductible	$0 copay	$500 copay per admission
Outpatient Care	$5 Copay Individual; $2 copay Group	$15 Copay Individual; $7 Copay Group	$20 copay Individual; $10 Copay Group	$20 copay	$20 copay	$15 copay	$20 copay

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Prescription Drug Benefits							
Retail Pharmacies							
Generic	$5 copay	$10 copay	$10 copay	$10 copay	$10 copay	$5 copay	$10 copay
Brand (Formulary/Preferred)	$5 copay	$30 copay	$30 copay	$30 copay	$30 copay	$20 copay	$30 copay
Brand (Non-Formulary/Non-preferred)	$5 copay (when approved)	$30 copay (when approved)	$30 copay (when authorized)	$60 copay	$60 copay	$20 copay	$50 copay
Specialty Drugs	20% coinsurance not to exceed $150/prescription (30 days)	20% coinsurance not to exceed $150/prescription (30 days)	20% coinsurance not to exceed $150/prescription	20% coinsurance up to $250/prescription	20% coinsurance up to $100/prescription	30% up to $150/RX	20% up to $200/RX
Days Supply	100 days	100 days	30 days	30 days	30 days	31 days	31 days
Mail Order							
Generic	$5 copay	$10 copay	$20 copay	$20 copay	$20 copay	$10 copay	$20 copay
Brand (Formulary/Preferred)	$5 copay	$30 copay	$60 copay	$60 copay	$60 copay	$40 copay	$60 copay
Brand (Non-Formulary/Non-preferred)	$5 copay (when approved)	$30 copay (when approved)	$90 copay	$120 copay	$120 copay	$40 copay	$100 copay
Specialty Drugs	20% coinsurance not to exceed $150/prescription (30 days)	20% coinsurance not to exceed $150/prescription (30 days)	20% coinsurance not to exceed $150/prescription (30 days)	20% coinsurance up to $100/prescription (30 day supply)	20% coinsurance up to $100/prescription (30 day supply)	30% up to $150/RX	20% up to $200/RX
Days Supply	100 days	100 days	100 days	100 days	100 days	90 days	90 days
Other Services and Supplies							
Vision Materials (Eyeglasses or contact lenses)	$175 Allowance every 24 months	$175 Allowance every 24 months	Not Covered	Not Covered	Not Covered	Not covered	Not covered
Durable Medical Equipment & Prosthetic Devices	100% in accordance with DME formulary	100% in accordance with DME formulary	20% in accordance with DME formulary	20% coinsurance	20% coinsurance after deductible	$0 copay	50% coinsurance
Home Health Care	$0 Copay, Up to 100 visits/year	$0 Copay, Up to 100 visits/year	$0 copay; Up to 100 visits/yr	$0 Copay, Up to 100 visits/year	$0 Copay, Up to 100 visits/year	$15 copay up to 100 visits/calendar year	$20 copay up to 100 visits/calendar year
Skilled Nursing or Extended Care Facility	$0 copay up to 100 days/benefit period	$0 copay up to 100 days/benefit period	10% coinsurance; up to 100 days/benefit period	$250 copay per admission	20% coinsurance after deductible, Up to 100 days/benefit period	$0 copay; up to 100 visits/ calendar year	$500 copay; up to 100 visits/calendar year
Hospice Care	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Chiropractic Services	$5 copay; up to 20 visits/yr	$5 copay; up to 20 visits/yr	$5 copay, up to 20 visits/year	$20 copay, Up to 20 visits/year (Combined with acupuncture)	$20 copay, Up to 20 visits/year (Combined with acupuncture)	$10 copay up to 30 visits/year	$10 copay up to 30 visits/year
Acupuncture Services	$5 copay; Physician referral required	$15 copay; Physician referral required	$20 copay; Physician referral required	$20 copay, Up to 20 visits/year (Combined with chiropractic)	$20 copay, Up to 20 visits/year (Combined with chiropractic)	$10 copay up to 30 visits/year	$10 copay up to 30 visits/year
Infertility Diagnosis/Treatment	$5 copay; See EOC for details	$15 copay; See EOC for details	50% coinsurance	50% of eligible expense	50% of eligible expense	6 procedures per lifetime covered at 50%, excluding IVF	6 procedures per lifetime covered at 50%, excluding IVF
Monthly Premiums							
EE Only	$1,226.19	$1,174.89	$1,082.24	$1,000.60	$817.20	$988.93	$928.09
EE +1 Dep	$2,452.37	$2,349.78	$2,164.48	$2,001.30	$1,634.50	$2,044.67	$1,917.02
EE + Family	$3,470.11	$3,324.94	$3,062.72	$2,781.70	$2,271.80	$2,910.73	$2,727.02

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