COUNTY OF SANTA CLARA
OVERVIEW COMPARISON OF MEDICAL PLAN FEATURES

Information contained in this document is meant to provide interested parties with general highlights and is not all inclusive of provisions and exclusions of each plan. Please refer to the plan brochure/disclosure for further details. This information is subject to change.

	KAISER	VALLEY HEALTH	HEALTH NET
Type of Plan:	HMO – Directed Services to Kaiser Facilities No Claim Forms	HMO – Directed Services to Valley Health Plan Network No Claim Forms	P.O.S. – Point of Service Plan Members may select from HMO, PPO or Out-of-Network Services
Service Area:	Reside within 30 mile radius of a Kaiser facility	Must live or work in Santa Clara County. For Retirees – Can reside in Santa Clara County or adjacent Counties – Contact plan for details	No service area restrictions
Deductibles:	$0.00	$0.00	HMO - $0.00 PPO - $0.00 Out-of-Network - $200.00 per member per calendar year
Office Visits:	$5.00	$0.00	HMO - $5.00 Office Visit PPO - $10.00 Office Visit Out-of-Network – 30% of Usual and Customary Charges
Hospital Services	No charge at a Kaiser facility	No Charge at Santa Clara Valley Medical Center (SCVMC)	HMO – No charge if referred by Primary Care Physician PPO – 10% with prior authorization Out-of-Network – 30% of Usual and Customary Charges
Prescriptions	$5.00 for 100 day supply	$0.00	Generic - $5.00 for 30 day supply Brand - $10.00 for 30 day supply Non-Formulary - $20.00 for 30 day supply
Mail Order Prescriptions	Yes – $5.00 for a 100 day supply	Yes – $0.00 co-paments	Generic - $10.00 for 90 day supply Brand - $20.00 for 90 day supply Non-Formulary - $40.00 for 90 supply
Chiropractic Services	None	$10.00 - 20 Visits per calendar year when pre-authorized.	HMO - $5.00 20 visits per calendar year PPO – Not covered Out-of-Network – Not covered

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Emergency Services	$5.00 at a Kaiser facility. Co-pay waived if admitted to hospital Services at a non-Kaiser facility are covered if deemed medically necessary by the plan. Must notify plan within 24-48 hours if you receive services from a non-Kaiser facility.	No charge at SCVMC. Services at other hospitals are covered if deemed medically necessary by the plan. Must notify plan within 24-48 hours if you receive services outside the plan hospital.	HMO - $35.00 at a participating Hospital. Co-pay waived if admitted. PPO – 10% of Usual and Customary Out-of-Network – 30% of Usual and Customary
Durable Medical Equipment	100% of covered equipment	100% of covered equipment	HMO – 100% of covered equipment PPO – 10% of covered equipment Out-of-Network – 30% of covered equipment
Mental Health – Outpatient If diagnosis meets the criteria under Assembly Bill 88, visit limitations may not apply. Check with your provider.	$5.00– 20 visits per calendar year	$10.00 – When Authorized by Plan there is no limit on the number of visits.	HMO - $35.00 if referred by Primary Care Physician PPO and Out-of-Network – 30% of Usual and Customary (Plan pays a maximum of $50.00 per visit) Maximum 20 visits per calendar year under all three options
Mental Health – Inpatient If diagnosis meets the criteria under Assembly Bill 88, visit limitations may not apply. Check with your provider	$0.00 – 45 days per calendar year	$0.00 - 45 days per calendar year	HMO - $0.00 , 30 days per calendar year PPO – 30% if Usual and Customary limited to 30 days per calendar year Out-of-Network - 30% of Usual and Customary limited to 30 days per calendar year
Well Woman Care	$5.00 Office Visit – Annual Exams as recommended by Plan	$0.00 Office Visit – Annual Exams as recommended by Plan	HMO - $5.00 Office Visit PPO - $10.00 Office Visit Out-of-Net – Not Covered Annual Exams as recommended by U.S. Preventative Health Task Force
Well Baby Care	$5.00 Office Visit	$0.00	HMO - $5.00 Office Visit PPO - $10.00 Office Visit Out-of-Network – 30% of Usual and customary