



Sweetwater Union High School District: OPER-258

Effective Period: January 1, 2024 - December 31, 2024

Acupuncture added to all plans for 2024, no other plan changes

Benefit Summary	NEW! VEBA Direct HMO \$10/100%	UHC Harmony HMO \$10/100%	UHC CS VEBA Alliance HMO \$20/\$30/\$500A
	What You Pay	What You Pay	What You Pay
Medical Deductible (individual/family)	None	None	None
Medical Out-of-Pocket Maximum (individual/family)	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Health Account	None	None	None
PCP Office Visit	\$10 copay	\$10 copay	\$20 copay
Specialist Office Visit	\$10 copay	\$10 copay	\$30 copay
Preventive Care	No charge	No charge	No charge
Inpatient Hospital Care	No charge	No charge	\$500 admit copay
Mental Health Services (outpatient/inpatient)	\$10 copay / No charge	\$10 copay / No charge	\$20 copay / \$500 admit copay
Substance Abuse Services (outpatient/inpatient)	No charge	No charge	No charge
Outpatient Diagnostic Laboratory and Radiology (standard procedures)	No charge	No charge	No charge
Complex Radiology (PET & MRI)	No charge	No charge	\$200 copay
Outpatient Surgery	No charge	No charge	\$250 copay
Outpatient Physical/Rehabilitation Therapy (Office Visit)	\$10 copay	\$10 copay	\$20 copay
Chiropractic and Acupuncture Services*	\$10 copay	\$10 copay	\$20 copay
Urgent Care (Office Visit only)	\$10 copay	\$10 copay	\$20 copay
Emergency Room (Copay waived if admitted)	\$100 copay	\$100 copay	\$150 copay
Rx Deductible (individual/family)	None	None	None
Rx Out-of-Pocket Maximum (individual/family)	\$3,000 / \$6,000	\$3,000 / \$6,000	\$1,600 / \$3,200
Rx Formulary List	National Preferred	National Preferred	National Preferred
Rx Pharmacy Network	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**
Short-Term Prescription Drugs*** (up to 30-day supply)	\$5 Generic \$25 PB 50% \$40 min \$175 max NPB	\$5 Generic \$25 PB 50% \$40 min \$175 max NPB	\$10 Generic \$30 PB 50% \$40 min \$175 max NPB
Long-Term Prescription Drugs*** (up to 90-day supply)	\$10 Generic \$50 PB 50% \$80 min \$350 max NPB	\$10 Generic \$50 PB 50% \$80 min \$350 max NPB	\$20 Generic \$60 PB 50% \$80 min \$350 max NPB
Available Medical Groups	Rady Children's Health Network, Sharp Community Medical Group, Sharp Rees-Stealy Medical Group, UC San Diego Medical Group	Sharp Community Medical Group, Sharp Rees-Stealy Medical Group, UC San Diego Medical Group	Mercy Physicians, Optum Care (Formerly Primary Care Associates), Rady Children's Health Network, Scripps Clinic, Scripps Coastal, Scripps Physician MG, UC San Diego Medical Group

Infertility services are excluded/not covered under non-Kaiser HMO plans and are included/covered under Kaiser HMO (excluding Kaiser Bronze) plans, please see your policies for details.

*Chiropractic and Acupuncture services have no annual visit maximums, must be medically necessary and may be subject to prior authorization from OptumHealth.

**Pay standard copays if you fill your prescription at an EAN Pharmacy (EAN Pharmacies include Rite Aid, Costco, Kmart, Vons, Haggen, Safeway, SuperValue, WinnDixie, Walmart, and many independent pharmacies) visit www.Express-scripts.com for a complete list of EAN pharmacies.

***Pay standard copays plus \$5/prescription if you fill your prescription at a non-EAN Pharmacy (Non-EAN Pharmacies include CVS, Walgreens, and certain independent pharmacies).

**You will pay the Retail Refill Allowance (RRA) penalty (equal to 2 times short-term medication copay for 30-day supply) if you fill long-term prescriptions at a network pharmacy other than Smart90 (Rite-Aid, Costco, and Sharp Rees Stealy Pharmacies).

**Copays waived for preferred generic hypertension, hypoglycemic, and cholesterol medications purchased at mail or Smart 90. This does not include normal retail use or brand drugs.

***G = Generic, P = Preferred, B = Brand, PB = Preferred Brand, NPB = Non-preferred Brand, S = Specialty

Disclaimer: Prepared by RPA San Diego on behalf of CS VEBA.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.



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Benefit Summary	SIMNSA HMO \$5; Rx: \$5 30-day What You Pay	Kaiser HMO \$0, Rx: \$5 / \$10 30-day What You Pay
Medical Deductible (individual/family)	None	None
Medical Out-of-Pocket Maximum (individual/family)	\$6,350 / \$12,700	\$1,500 / \$3,000
Health Account	None	None
PCP Office Visit	\$5 copay	No charge
Specialist Office Visit	\$5 copay	No charge
Preventive Care	No charge	No charge
Inpatient Hospital Care	No charge	No charge
Mental Health Services (outpatient/inpatient)	\$5 copay / No charge	No charge
Substance Abuse Services (outpatient/inpatient)	\$5 copay / No charge	No charge
Outpatient Diagnostic Laboratory and Radiology (standard procedures)	No charge	No charge
Complex Radiology (PET & MRI)	No charge	No charge
Outpatient Surgery	No charge	No charge
Outpatient Physical/Rehabilitation Therapy (Office Visit)	\$10 copay	No charge
Chiropractic and Acupuncture Services*	Not covered	\$10 copay
Urgent Care (Office Visit only)	\$25 copay	No charge
Emergency Room (Copay waived if admitted)	\$250 copay (U.S. or out of plan area)	\$50 copay
Rx Deductible (individual/family)	None	None
Rx Out-of-Pocket Maximum (individual/family)	N/A	N/A
Rx Formulary List	SIMNSA	Kaiser
Rx Pharmacy Network	SIMNSA	Kaiser
Short-Term Prescription Drugs*** (up to 30-day supply)	\$5 copay	G: \$5 copay B: \$10 copay (up to a 30-day supply)
Long-Term Prescription Drugs*** (up to 90-day supply)	Not available	G: \$10 copay B: \$20 copay (up to a 100-day supply)
Available Medical Groups	SIMNSA	Kaiser

Infertility services are excluded/not covered under non-Kaiser HMO plans and are included/covered under Kaiser HMO (excluding Kaiser Bronze) plans, please see your policies for details.

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Benefit Summary	UMR NexusACO PPO - No HRA	
	In Network What You Pay	Out of Network What You Pay
Medical Deductible (individual/family)	\$2,000 / \$4,000	\$2,000 / \$4,000
Medical Out-of-Pocket Maximum (individual/family)	\$5,000 / \$10,000	\$5,000 / \$10,000
Health Account	None	
PCP Office Visit	Tier 1 Physician: \$30 copay Tier 2 Physician: 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Specialist Office Visit	Tier 1 Physician: \$50 copay Tier 2 Physician: 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Preventive Care	No charge	No coverage for non-network services
Inpatient Hospital Care	20% coinsurance (after deductible)	50% coinsurance with Prior Authorization (after deductible)
Mental Health Services (outpatient/inpatient)	\$30 copay / 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Substance Abuse Services (outpatient/inpatient)	\$30 copay / 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Outpatient Diagnostic Laboratory and Radiology (standard procedures) <i>Freestanding Facility or Physician Office OR</i>	No charge	50% coinsurance (after deductible)
<i>Hospital-based Lab or Radiology</i>	20% coinsurance (deductible does not apply)	
Complex Radiology (PET & MRI) <i>Freestanding Facility or Physician Office OR</i>	20% coinsurance (after deductible)	50% coinsurance (after deductible)
<i>Hospital-based Complex Radiology</i>	20% coinsurance (after deductible)	
Outpatient Surgery <i>Ambulatory Surgery Center or Physician's Office</i>	20% coinsurance (after deductible)	50% coinsurance with Prior Authorization (after deductible)
<i>Outpatient Hospital-based Surgical Center</i>	20% coinsurance (after deductible) and \$100 copayment	
Outpatient Physical/Rehabilitation Therapy (Office Visit)	\$30 copay	50% coinsurance (after deductible)
Chiropractic and Acupuncture Services*	\$30 copay	50% coinsurance (after deductible)
Urgent Care (Office Visit only)	\$50 copay	50% coinsurance (after deductible)
Emergency Room (Copay waived if admitted)	\$100 copay	\$100 copay
Rx Deductible (individual/family)	None	
Rx Out-of-Pocket Maximum (individual/family)	\$1,600 / \$3,200	
Rx Formulary List	National Preferred	
Rx Pharmacy Network	Express Advantage Network**	
Short-Term Prescription Drugs*** <i>(up to 30-day supply)</i>	\$10 Generic \$30 PB 50% \$40 min \$175 max NPB	Retail: with submission of a paper claim, member will be reimbursed at the rate the Plan would have paid had the member used an in-network pharmacy less the member's copay.
Long-Term Prescription Drugs*** <i>(up to 90-day supply)</i>	\$20 Generic \$60 PB 50% \$80 min \$350 max NPB	No coverage for non-network pharmacy
Available Medical Groups	Check umr.com to find Tier 1 physicians near you	All others

Infertility services are excluded/not covered under PPO plans, please see your policy for details.

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