Jefferson Union HSD PLAN Comparison

Health Benefit Options

Effective: January 1, 2020

Plan Name	Kaiser Traditional Plan "High Plan" - $20 Copay	Kaiser Deductible HMO Plan "Low Plan" - $40 Copay	MCSIG Blue Shield PPO $25	MCSIG Blue Shield HMO
General Plan Information				
Annual Deductible (Individual/Family)	$0/$0	$3,000/$6,000	$650/$1,300	$0/$0
Coinsurance	100%	30%	20% in network/40% out of network	100%
Office Visit/Exam	$20 copay	$40 copay (deductible does not apply)	$25 in network/40% out of network	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$6,000	$4,000 in network/$7,000 out of network	$2,500
Annual Out-of-Pocket Limit/Family	$3,000	$12,000	$8,000 in network/$14,000 out of network	$5,000
Outpatient Services				
Most Preventive Care Services	No charge	No charge	0% in network/40% out of network	No charge
Outpatient Surgery Charge	$20 copay	$40 copay (deductible does not apply)	20% in network/40% out of network	$300 copay
Outpatient Rehab Therapy Services	$20 copay	$40 copay (deductible does not apply)	20% in network/40% out of network	No charge
Diagnostic X-Ray and Lab Tests	No charge	$10 copay (deductible does not apply)	20% in network/40% out of network	No charge
Inpatient Hospital Services				
Inpatient Hospitalization	No charge	30% coinsurance after deductible	20% in network/40% out of network	$500 copay
Emergency Services				
Emergency Room Copay (waived if admitted)	$50 copay	30% coinsurance after deductible	20%	$100 copay
Urgent Care				
Urgent Care Facility	$20 copay	$40 copay (deductible does not apply)	$25 in network/40% out of network	$20 copay
Mental Health & Substance Abuse				
Inpatient Care	No charge	30% coinsurance after deductible	20% in network/40% out of network	$500 copay
Outpatient Care	$20 copay	$40 copay (deductible does not apply)	20% in network/40% out of network	$20 copay
Prescription Drug Benefits				
Rx Annual Out-of-Pocket Limit (Ind/Family)	n/a	n/a	$1,800/$3,600	n/a
Generic	$10 for up to 100-day supply for most covered outpatient items in accord with Kaiser drug formulary guidelines	$10 copay	$7 copay	$10 copay
Brand (Formulary/Preferred)		$30 copay	$20 copay	$30 copay
Brand (Non-Formulary/Non-preferred)			$35 copay	$50 copay
Number of Days Supply	up to 100 days	30 days	30 days	30 days
Mail Order				
Generic	$10 for up to 100-day supply for most covered outpatient items in accord with Kaiser drug formulary guidelines	$20 copay	$0	$20 copay
Brand (Formulary/Preferred)		$60 copay	$50 copay	$60 copay
Brand (Non-Formulary/Non-preferred)			$70 copay	$100 copay
Number of Days Supply for Mail Order	up to 100 days	100 days	90 days	90 days
Other Services and Supplies				
Durable Medical Equipment	20% coinsurance	20% coinsurance (deductible does not apply)	20% in network/40% out of network	50%
Home Health Care	No charge up to 100 visits/calendar year	No charge up to 100 visits/calendar year	20% in network/20% out of network	$20 copay up to 100 visits per year
Chiropractic Services	$15 copay (30 visits/year)	n/a	n/a	$10 copay - 30 combined visits per year
Acupuncture	$15 copay (30 visits/year)	n/a	$2,000 per year	
Vision				
Vision Appliances	Eyewear purchased at Plan Medical Offices or plan optical sales offices $175 allowance every 24 months	Not covered	Not covered	Not covered
2020 Rates				
EE Only	$724.16	$561.04	$982.00	$1,005.00
EE + One	$1,448.31	$1,122.08	$1,960.00	$2,055.00
EE + Two or More	$2,049.37	$1,587.75	$2,546.00	$2,912.00