

# Jefferson Union HSD PLAN Comparison

## Health Benefit Options

Effective: January 1, 2020

Plan Name	Kaiser Traditional Plan	Kaiser Deductible HMO Plan	MCSIG Blue Shield	MCSIG Blue Shield
	"High Plan" - \$20 Copay	"Low Plan" - \$40 Copay	PPO \$25	HMO
<b>General Plan Information</b>				
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
<b>Outpatient Services</b>				
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
<b>Inpatient Hospital Services</b>				
Inpatient Hospitalization	No charge	30% coinsurance after deductible	20% in network/40% out of network	\$500 copay
<b>Emergency Services</b>				
Emergency Room Copay (waived if admitted)	\$50 copay	30% coinsurance after deductible	20%	\$100 copay
<b>Urgent Care</b>				
Urgent Care Facility	\$20 copay	\$40 copay (deductible does not apply)	\$25 in network/40% out of network	\$20 copay
<b>Mental Health &amp; Substance Abuse</b>				
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
<b>Prescription Drug Benefits</b>				
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	\$10 copay	\$7 copay	\$10 copay
Brand (Formulary/Preferred)	for most covered outpatient items in accord	\$30 copay	\$20 copay	\$30 copay
Brand (Non-Formulary/Non-preferred)	with Kaiser drug formulary guidelines		\$35 copay	\$50 copay
Number of Days Supply	up to 100 days	30 days	30 days	30 days
<b>Mail Order</b>				
Generic	\$10 for up to 100-day supply	\$20 copay	\$0	\$20 copay
Brand (Formulary/Preferred)	for most covered outpatient items in accord	\$60 copay	\$50 copay	\$60 copay
Brand (Non-Formulary/Non-preferred)	with Kaiser drug formulary guidelines		\$70 copay	\$100 copay
Number of Days Supply for Mail Order	up to 100 days	100 days	90 days	90 days
<b>Other Services and Supplies</b>				
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	
<b>Vision</b>				
Vision Appliances	Eyewear purchased at Plan Medical Offices or plan optical sales offices \$175 allowance every 24 months	Not covered	Not covered	Not covered
<b>2020 Rates</b>				
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

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