Keenan & Associates

Jefferson Union High School District

Medical Plans Comparison effective January 1, 2019

Effective Date Carrier Name Plan Name	1/1/2019 Kaiser Traditional Plan "High Plan" - $20 Copay	1/1/2019 Kaiser Deductible HMO Plan "Low Plan" - $40 Copay	1/1/2019 MCSIG Anthem EPO Plan Premier 30	1/1/2019 MCSIG Anthem HMO Plan 20/40/250A/1250OP
General Plan Information	Kaiser Plan Providers	Kaiser Plan Providers	Anthem PPO Participating Providers	Anthem HMO Participating Providers
Annual Deductible - Individual/Family	n/a	$3,000/$6,000	n/a	n/a
Coinsurance	100%	30%/70%	100%	100%
Office Visit/Exam	$20 copay	$40 copay (deductible doesn't apply)	$30 copay	$20 copay
Annual OOP - Individual/Family	$1,500/$3,000	$6,000/$12,000	$2,000/$4,000	$2,000/$4,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Services				
Well-Child Care	No charge	No charge	No charge	No charge
Adult Periodic Exam with Preventive Tests	No charge	No charge	No charge	No charge
Pregnancy & Maternity Care (Pre-Natal Care)	No charge	No charge	$30 copay	$20 copay
Diagnostic X-ray and Lab	No charge	$10 copay (deductible doesn't apply)	No charge	No charge (Advanced imaging: $100 per test)
Outpatient Rehab Therapy Services	$20 copay	$40 copay (deductible doesn't apply)	$30 copay	$20 copay
Outpatient Surgery	$20 copay	30% coinsurance after deductible	$100 copay	$125 copay
Inpatient Hospital Services				
Semi-Private Room & Board; including services & supplies	No charge	30% coinsurance after deductible	$200 copay/admit	$250 copay per admission
Emergency Services				
Emergency Room	$50 copay (waived if admitted)	30% coinsurance after deductible	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Urgent Care Facility	$20 copay	$40 copay (deductible doesn't apply)	$30 copay	$20 copay
Mental Health & Substance Abuse Benefits				
Inpatient Care	No charge	30% coinsurance after deductible	No charge	$250 copay per admission
Outpatient Care	$20 copay	$40 copay Individual (deductible doesn't apply)	$15 copay	$20 copay
Prescription Drug Benefits				
Prescription Drug Deductible	n/a	n/a	n/a	n/a
Generic	$10 for up to 100-day supply for most covered outpatient items in accord with Kaiser drug formulary guidelines at Plan Pharmacies or through mail-order service	$10 copay	$7 / $9.50 (retail/maintenance)	$5 copay (Tier 1a) $15.00 copay (Tier 1b)
Brand (Formulary/Preferred)		$30 copay	$20 / $29 (retail/maintenance)	$30 copay
Brand (Non-Formulary/Non-Preferred)			$35 / $44 (retail/maintenance)	$50 copay/30% to $150 Specialty
Number of Days Supply		30 days	30 days	30 days
Mail Order				
Generic		$20 copay	$0	$12.50 copay (Tier 1a) $37.50 copay (Tier 1b)
Brand (Formulary/Preferred)		$60 copay	$40	$90
Brand (Non-Formulary/Non-Preferred)			$70	$150 copay/30% to $250 Specialty
Number of Days Supply for Mail Order		100 days	90 days	90 days

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Other Services and Supplies				
Durable Medical Equipment	20% coinsurance	20% coinsurance (deductible doesn't apply)	20% coinsurance	20% coinsurance
Home Health Care	No charge up to 100 visits/calendar year	No charge (deductible doesn't apply) up to 100 visits/calendar year	$30 copay up to 120 days/illness	No charge up to 100 visits/calendar year
Chiropractic	$15 copay up to 30 visits/year	n/a	Benefits provided by CHPC; Must use CHPC Network Provider $10 copay	$20 copay in office, $40 copay in outpatient hospital (limited to 60 day limit per benefit period for Physical, Occupational & Speech Therapy
Acupuncture Services	$15 copay up to 30 visits/year	n/a	$30 copay/up to a maximum of $2000	$20 copay
Vision Services				
Vision Appliances	Eyewear purchased at Plan Medical Offices or plan optical sales offices $175 allowance every 24 months	Not Covered	$15 copay 12/24/24	Not Covered
Rates				
Employee	$724.89	$562.23	$1,108	$824
Employee + 1	$1,449.78	$1,124.47	$2,204	$1,685
Employee + Family	$2,051.44	$1,591.12	$2,871	$2,388

MCSIG

San Mateo County Schools Insurance Group
Medical 2019 PPO Plan Comparison

Reflecting the cost the member would pay	PPO $25 Anthem Prudent Buyer	EPO $30 No Deductible Prudent Buyer
Deductibles (Individual / Family)	$650 / 2x	None
Coinsurance - Network	20%	0%
Coinsurance - Out Network	40%	No out of network coverage.
Out-of-Pocket Co-Ins Maximums - Single In Network	$4,000	$2,000
Out-of-Pocket Co-Ins Maximums - Family In Network	2 x Individual	2 x Individual
Out-Network Co-Insurance Maximums	$7,000 / 2 x Ind	No out of network coverage
Inpatient Hospital Coinsurance (In-Network)	20%	0%
Inpatient Hospital Coinsurance (Out-Network)	40%	No out of network coverage Emergency Services Only
Separate Hospital ER Co-Pay (*applies only if non-emergency*)	$250 ER Room	$100 ER Room
Ground/Air Ambulance	20%/20%	$100 / 20%
Physician Benefits	In-Net/Out-Net	In Network Only
Surgery/Anesthesia	20% / 40%	0%
Hospital Visits	20% / 40%	$200 per Admit
Office Visits	$25 / 40%	$30
Specialist Visits	$35 / 40%	$30
Physical Exams	0% /40%	0%
Chiropractic Care -*Coverage for in Network only*	$10 copay	$10 copay
~Must use Chiropractic HealthPlan Network only		
Mental Health/Substance Abuse - *MHN*	Outptnt: $15/visit network; 40% out-of-network	Outptnt: $15/visit network; 40% out-of-network
~Must use MHN Network only	Inpatient: 100% in-network; 40% out-of-network	Inpatient: 100% in-network; 40% out-of-network
Other Benefits	In-Net/Out-Net	In Network Only
Well Child Care	0% / 40%	0%
Maternity Care	20% / 40%	$30
Skilled Nursing Facility* (to 365 days/Lifetime)	20%	0%
Home Health Care* (to 120 days-per illness)	20%	$30
Outpatient Diagnostic X-ray and Lab Work	20% / 40%	0%
Acupuncture (Any Licensed Acupuncturist)	$2,000 per year	$30
Durable Medical Equipment	20% / 40%	20%
Outpatient surgery @ Ambulatory Surgery Center	20% / 40%	$100
Outpatient Rehab/Physical/Occupational Therapy	20% / 40%	$30
Prescription Drugs		
Retail - Generic/Preferred/Brand (NonFormulary)	$7 / $20 / $35 30 day supply	$7 / $20 / $35 30 day supply
Retail/Mtce. - Gen./Pref./Brand (NonFormulary)	$9.50 / $29 / $44 30 day supply	$9.50 / $29 / $44 30 day supply
Mail - Generic/Preferred/Brand (NonFormulary)	$0 / $40 / $70 - 90 day supply	$0 / $40 / $70 - 90 day supply
Specialty	$21 / $60 / $100 30 day supply	$21 / $60 / $100 30 day supply
	No Vision	Vision 12/24/24
	Rate	Rate
Employee	$876	$1,108
Employee + one	$1,749	$2,204
Employee + two or more	$2,272	$2,871