Keenan Associates

RENEWAL 2018

# Washington Unified School District

## Summary of HMO Plans

### WHA HMO & BLUE SHIELD TRIO - January 1, 2018

| | Current | Current | Proposed | Current | Current |
|---|---|---|---|---|---|
| Effective Date | 01/01/2018 | 01/01/2018 | 01/01/2018 | 01/01/2018 | 01/01/2018 |
| Carrier Name | WHA | WHA | Blue Shield ACO Trio | WHA | WHA |
| Plan Name | HMO - Certificated | HMO - Classified | HMO - Certificated & Classified | HMO - High Deductible Certificated | HMO - High Deductible Classified |
| Eligible Class | Eligible Employees | Eligible Employees | Eligibile Employees | Eligible Employees | Eligible Employees |
| **Mental Health Benefits** | | | | | |
| Inpatient Care | $250 copay per admit | $250 copay per admit | $250 copay per admit | 100% after cal yr deductible | 100% after cal year deductible |
| Outpatient Care | $20 copay | $20 copay | $20 copay | 100% after cal yr deductible | 100% after cal year deductible |
| **Substance Abuse** | | | | | |
| **Inpatient Care** | | | | | |
| Inpatient Hospitalization | $250 copay per admit | $250 copay per admit | $250 copay per admit | 100% after cal yr deductible | 100% after cal year deductible |
| Inpatient Detoxification Services | $250 copay per admit | $250 copay per admit | $250 copay per admit | 100% after cal yr deductible | 100% after cal year deductible |
| **Outpatient Care** | | | | | |
| Outpatient Services | $20 copay | $20 copay | $20 copay | 100% after cal yr deductible | 100% after cal year deductible |
| **Prescription Drug Benefits** | | | | | |
| Prescription Drug Deductible | N/A | N/A | N/A | Subject to plan deductible | Subject to plan deductible |
| Prescription Drug Annual Out-of-Pocket Limit/Individual | Will accrue to Annual OOP Max | Will accrue to Annual OOP Max | Will accrue to Annual OOP Max | Will accrue to annual OOP Maximum | Will accrue to annual OOP Maximum |
| Prescription Drug Annual Out-of-Pocket Limit/Family | Will accrue to Annual OOP Max | Will accrue to Annual OOP Max | Will accrue to Annual OOP Max | Will accrue to annual OOP Maximum | Will accrue to annual OOP Maximum |
| Generic | $10 copay | $10 copay | $10 copay | 100% after cal yr deductible | 100% after cal year deductible |
| Brand (Formulary/Preferred) | $30 copay | $30 copay | $25 copay | $30 copay after cal yr dedutible | $30 copay after cal year deductible |
| Brand (Non-Formulary/Non-preferred) | $50 copay | $50 copay | $25 copay | $50 copay after cal yr deductible | $50 copay after cal year deductible |
| Number of Days Supply | 30 days | 30 days | 30 days | 30 days | 30 days |
| **Mail Order** | | | | | |
| Generic | $25 copay | $25 copay | $20 copay | 100% after cal yr deductible | 100% after cal year deductible |
| Brand (Formulary/Preferred) | $75 copay | $75 copay | $50 copay | $75 copay after cal yr deductible | $75 copay after cal year deductible |
| Brand (Non-Formulary/Non-preferred) | $125 copay | $125 copay | $50 copay | $125 copay after cal yr deductible | $125 copay after cal year deductible |
| Number of Days Supply for Mail Order | 90 days | 90 days | 90 days | 90 days | 90 days |
| **Other Services and Supplies** | | | | | |
| Durable Medical Equipment & Prosthetic Devices | 20% copay (does not count towards out of pocket maximum) | 20% copay (does not count towards out of pocket maximum) | 20% copay (does not count towards out of pocket maximum) | 100% after cal yr deductible | 100% after cal year deductible |
| Home Health Care | 100% (Limited to 100 visits/ cal yr) | 100% (Limited to 100 visits/ cal yr) | 100% (Limited to 100 visits/ cal yr) | 100% after cal yr deductible | 100% after cal year deductible |
| Skilled Nursing or Extended Care Facility | $250 copay per admit (Limit of 100 days/ cal yr) | $250 copay per admit (Limit of 100 days/ cal yr) | $250 copay per admit (Limit of 100 days/ cal yr) | 100% after cal yr deductible | 100% after cal year deductible |
| Hospice Care | 100% | 100% | 100% | 100% after cal yr deductible | 100% after cal year deductible |
| Chiropractic Services | $15 copay (Limit of 20 visits/ cal yr) | $15 copay (Limit of 20 visits/ cal yr) | $10 copay (Limit of 30 visits/ cal yr) combined with acupuncture | $15 copay; 20 visits per cal year | $15 copay; 20 visits per cal year |
| Acupuncture | $15 copay (Limit of 20 visits/ cal yr) | $15 copay (Limit of 20 visits/ cal yr) | $10 copay (Limit of 30 visits/ cal yr) combined with chiropractic | $15 copay; 20 visits per cal year | $15 copay; 20 visits per cal year |
| **Vision** | | | | | |
| Examination | $20 copay | 100%; exam every 12 months | $20 copay | 100% after cal yr deductible | 100%; exam every 12 months |
| Materials | Not covered | Benefits through MES Vision | TBD | Not covered | Benefits through MES Vision |
| **Hearing** | | | | | |
| Screening | $20 copay | $20 copay | $20 copay | 100% after cal yr deductible | 100% after cal year deductible |
| Aid(s) | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Infertility** | | | | | |
| Diagnosis | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations |
| Treatment | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations | See Plan Certificate for limitations |