LYNDEN SCHOOL DISTRICT BASIC MEDICAL BENEFITS COMPARISON 2018-19

| SERVICE | KAISER WELCOME 500 Managed Care | PREMERA BLUE CROSS EASYCHOICE A | PREMERA BLUE CROSS EASYCHOICE B | PREMERA BLUE CROSS BASIC | PREMERA BLUE CROSS QHDHP / HSA |
|---|---|---|---|---|---|
| **Deductible** | $500/person<br>$1,500/family | $1,250/person<br>$3,750/family | $750/person<br>$2250/family | $2,100/person<br>$4,200/family | $1,750/person<br>$3,500/family* |
| **Out-of-Pocket Maximum** | $2,000/person<br>$6,000/family<br>All patient cost shares apply to out-of-pocket maximum. | $4,000/person<br>$8,000/family<br>All patient cost shares apply to out-of-pocket maximum. | $3,500/person<br>$7,000/family<br>All patient cost shares apply to out-of-pocket maximum. | $6,600/person<br>$13,200/family<br>All patient cost shares apply to out-of-pocket maximum. | $5,000/person<br>$10,000/family<br>All patient cost shares apply to out-of-pocket maximum. |
| **In-Network Coinsurance** | 80% | 80% | 75% | 70% | 80% |
| **Physician's Office Visit** | Visits 1-4 100% after $20 copay (dw)<br>Visits 5+ subject to $20 copay, deductible; then covered at 80% | $25 copay in-network (dw)<br>$35 copay specialist in-network (dw) | $30 copay in-network (dw)<br>$40 copay specialist in-net. (dw)<br>50% out-of-net. (non-specialist and specialist) | Non-specialist: $35 copay (dw)<br>Specialist: $50 copay (dw) | 80% after deductible |
| **Diagnostic Services** | Paid in full to $500 PCY.<br>Deductible, then 80% thereafter. | Paid in full to $1,000 PCY.<br>Deductible , then 80% thereafter. | 75% after deductible | 70% after deductible | 80% after deductible |
| **Prescriptions Pharmacy (30 Day Supply)** | $15 copay generic<br>$30 copay brand | $10 generic; 30% preferred; 30% non-preferred; 30% specialty<br>$500 ded waived for generics | $5 generic; $30 preferred; $45 non-preferred; 30% specialty<br>$250 ded waived for generics | $750 Ded then: $15 copay generic formulary.<br>$30 copay brand formulary.<br>$50 copay non-form. / 30% specialty | 80% after deductible |
| **Prescriptions Mail Order (90 Day Supply)** | $30 copay generic<br>$60 copay brand | $20 generic; 30% preferred; 30% non-preferred; 30% specialty-30 day supply<br>$500 ded waived for generics | $10 generic; $75 preferred; $112 non-preferred; 30% specialty-30 day supply<br>$250 ded waived for generics | $750 Ded shared with retail then:<br>$30 copay generic formulary.<br>$60 copay brand formulary.<br>$100 copay non-form / 30% specialty | 80% after deductible |
| **Preventive Care** | Covered in full.<br>No annual maximum. | Covered in full.<br>No annual maximum. | Covered in full.<br>No annual maximum. | Covered in full.<br>No annual maximum. | Covered in full.<br>No annual maximum. |
| **Emergency room (copay waived if admitted)** | $100 copay, then ded. & 80% | $100 copay, then ded. & 80% | $150 copay, then ded. & 80% | $200 copay, then ded. & 70% | 80% after deductible |
| **Hospital Inpatient** | 80% after deductible | 80% after deductible | 75% after deductible | 70% after deductible | 80% after deductible |
| **Ambulance** | 80% after deductible | 80% after deductible | 75% after deductible | 70% after deductible | 80% after deductible |

**RATE TIERS:**

| | | | | | |
|---|---|---|---|---|---|
| **Employee Only** | $753.96 | $711.09 | $711.09 | $573.93 | $707.92 |
| **Employee & Spouse** | $1,441.80 | $1,292.70 | $1,292.70 | $1,042.48 | $1,183.83 |
| **Employee & Children** | $1,146.93 | $943.78 | $943.78 | $761.35 | $898.32 |
| **Employee & Family** | $1,833.60 | $1,549.14 | $1,549.14 | $1,249.02 | $1,376.32 |

*PREMERA QHDHP / HSA: Prior to benefits being paid out for any family member, the deductible must be met. The family deductible applies with the subscriber and one or more dependents are enrolled. A single member on family coverage will not pay more than $5,000 OOPM for annual cost sharing. When a single member on family coverage reaches the $5,000 OOPM, benefits will be paid at 100% of the allowed amount for that member.

dw= deductible waived