West Ottawa Public Schools

Package Code	029	040/ 041	046/ 047	PH05	PH06
Vendor	BCBS	BCBS	BCBS	Priority Health	Priority Health
Plan Name	Enhanced 1000 029	Enhanced HSA 2000 040/ 041	Value HSA 3000 046/ 047	Priority HSA 3500 PH05	Priority HSA 3500 PH06
Plan Highlights	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Individual Deductible	$1,000	$2,000	$3,000	$3,500	$3,500
Family Deductible	$2,000	$4,000	$6,000	$7,000	$7,000
Coinsurance (Insurance Pays)	80%	100%	80%	100%	80%
Individual Coinsurance Max	$2,500	N/A	N/A	$2,000	$2,000
Family Coinsurance Max	$5,000	N/A	N/A	$4,000	$4,000
Individual Out of Pocket Max	$4,500	$3,000	$4,000 ($6,550 per member in a family plan)	$5,500	$5,500
Family Out of Pocket Max	$9,000	$6,000	$8,000	$11,000 (but not to exceed $10,600 per person in the family)	$11,000 (but not to exceed $10,600 per person in the family)
Covered Benefits					
Preventative Care	100% covered	100% covered	100% covered	100% covered	100% covered
Primary Care Physician Office Visit	$20	100%, after deductible	80%, after deductible	100%, after deductible	80%, after deductible
Specialist Office Visit	$20	100%, after deductible	80%, after deductible	100%, after deductible	80%, after deductible
Urgent Care Visit	$20	100%, after deductible	80%, after deductible	100%, after deductible	80%, after deductible
Emergency Room	$50	100%, after deductible	80%, after deductible	100%, after deductible	80%, after deductible
	Cost per Visit	**Cost per Visit**	**Cost per Visit**	**Cost per Visit**	**Cost per Visit**
Chiropractic	$20 copay (24 visits per calendar year)	100%, after deductible (24 visits per calendar year)	80%, after deductible (12 visits per calendar year)	100%, after deductible (24 visits per calendar year)	80%, after deductible (24 visits per calendar year)
PT/OT/Speech combined	80% Combined limit to 60 visits per Calendar Year	100% after deductible (Combined limit to 60 visits per Calendar Year)	80%, after deductible (Combined limit to 30 visits per Calendar Year)	100% after deductible (Combined limit to 60 visits per Calendar Year)	80% after deductible (Combined limit to 60 visits per Calendar Year)
Prescription Drugs					
Generic	$10	$10 copay, after deductible	$15 copay, after deductible	$10 copay, after deductible	$10 copay, after deductible
Preferred Brand	$40	$40 copay, after deductible	$30 copay, after deductible	20%, after deductible (minimum $40, maximum $80)	20%, after deductible (minimum $40, maximum $80)
Non-Preferred Brand	$40	$40 copay, after deductible	$60 copay, after deductible	20%, after deductible (minimum $80, maximum $160)	20%, after deductible (minimum $80, maximum $160)
Mail Order Prescriptions (90 Days)	1x	2x	2x	2x	2x