No._____

UNITED INDEPENDENT SCHOOL DISTRICT
AGENDA ACTION ITEM

TOPIC Approval of District Group Health Insurance HMO Plan Rates, District Contributions
SUBMITTED BY: Ofelia Dominguez, Director OF: Risk Management

APPROVED FOR TRANSMITTAL TO SCHOOL BOARD: _____

DATE ASSIGNED FOR BOARD CONSIDERATION: June 14, 2022

RECOMMENDATION:
It is recommended that the United ISD Board approve the District Group Health Self- Insurance Rates, District Contributions and HMO Plan Changes. The Employee Benefits Committee (EBC) and administration has concluded a review of the district-self-insured health plan and is prepared to make the following recommendations for Board Approval. Employee Benefits Committee (EBC) unanimously voted to approve these changes.

Plan Year: September 1, 2022 to August 31, 2023
Increase District Contribution to $475.00 vs. Current $425.00
Insurance Plans:
Plan Name Category
HMO Plan (BRONZE): Second Year Introductory Plan
Less Cost contribution from Employee to $41.12 Per Employee/Per Month
Coverage: Requires Primary Care Provider; No Out-of-Network Coverage
No Out of State Coverage
Coverage Mirrors Core Plan (SILVER) –Schedule of Benefits Attached

Core Plan (SILVER): No Changes in Coverage nor Cost to Employee $81.12 Per Employee/Per Month

Core Plan Plus (GOLD): No Changes in Coverage nor Cost to Employee $170.62 Per Employee/Per Mnth

RATIONALE:
In school year 2015-2016 the UISD Board of Trustees approved the implementation of a self-insured health plan for employees. The Health Plan is completing its seventh year of service..

BUDGETARY INFORMATION:
It is projected that Board Contributions and employee contributions will be sufficient to cover all costs of the district health insurance plan.

BOARD POLICY REFERENCE AND COMPLIANCE:
Texas Education Code 22.0

Blue Cross Blue Shield Of DESCRIPTIONS		UISD Health Schedule of Benefits: 2022-2023				
		BRONZE	SILVER		GOLD	
Network Type		In-Network ONLY (Service Only in Texas)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)
Plan Limits	Overall deductibles limits	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
	Out-of-pocket limits	$8,150 Individual $16,300 Family	$8,150 Individual $16,300 Family	$17,000 Individual $34,000 Family	$8,150 Individual $16,300 Family	$17,000 Individual $34,000 Family
	Co-Insurance Responsibility (Employee/Provider)	30% / 70%	30% / 70%	50% / 50%	30% / 70%	50% / 50%
Visit to a Health Care Provider's Clinic or Office (HMO Plan requires a PCP referral to see an specialist)						
MD Visits	Virtual visit (MD Live)	Not Available	$15 Copay	N/A	$15 Copay	N/A
	Primary care visit	$35 Copay	$35 Copay		$35 Copay	
	Specialist visit	$60 Copay	$60 Copay	50% Coinsurance	$45 Copay	50% Coinsurance
	Preventive Care/Screening/Immunizatio	$0	$0		$0	
If You Have A Test						
Costs	Diagnostic test (x-ray, blood work)	No Charge	No Charge		No Charge	
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	30% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance
	Home Health Care	No Charge; deductible does not apply	No Charge; deductible does not apply		No Charge; deductible does not apply	
Mental Health, behavioral health, or substance abuse services (Certain services must be preauthorized)						
Mental Health	Outpatient services	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	50% coinsurance	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	50% coinsurance
	Inpatient services	30% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	50% coinsurance (Other fees & penalties may apply)	30% coinsurance; deductible does not apply	50% coinsurance (Other fees & penalties may apply)
Emergency Services (for a list of urgent care clinics please visit the RM Website)						
Emergency	Emergency Room Care (Copay waived if admitted)	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	30% Coinsurance	30% Coinsurance	30% Coinsurance
	Urgent Care Clinics	$35 - $75 Copay Visit*	$35 - $75 Copay Visit*	50% Coinsurance	$35 - $75 Copay Visit*	50% Coinsurance
Hospital Services						
Hospital	Doctor's Hospital/Laredo Medical Center	Yes (In-network)	Yes (In-network)	N/A	Yes (In-network)	N/A
	Facility Fee (if you stay in the hospital) Physician/Surgeon Fees (if you stay in the hospital)	30% Coinsurance	30% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance
Recovery Services (Preauthorizations and limited visits are in force, for more info visit the RM Website)						
Special Care Needs	Home Health Care	No Charge; Deductible does not apply	No Charge; Deductible does not apply	50% Coinsurance	No Charge; Deductible does not apply	50% Coinsurance
	Skilled nursing care					
	Rehabilitation Services	$35 copay PCP/ $60 copay SPC; deductible does not apply	$35 copay PCP/ $60 copay SPC; deductible does not apply	50% Coinsurance	$35 copay PCP/ $45 copay SPC; deductible does not apply	50% Coinsurance
	Habilitation Services					
	Durable Medical Equipment	30% Coinsurance	30% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance
RX Costs (Generic/Preferred/Non-Preferred)						
Costs	Retail	$10/$60/$105 Copay	$10/$60/$105 Copay	$10/$60/$105 plus 50% Coinsurance	$10/$50/$80 Copay	$10/$50/$80 plus 50% Coinsurance
	Mail-order (90-Day Supply)	$20/$120/$210 Copay	$20/$120/$210 Copay	Not Covered	$20/$100/$160 Copay	Not Covered
Specialty Drugs						
	Specialty Drugs	$250 Copay	$250 Copay	Not Covered	$250 Copay	Not Covered
	District Contribution	$475.00	$475.00		$475.00	
Monthly Cost		Employee Contribution	Full Cost	Employee Contribution	Full Cost	Employee Contribution	Full Cost
	Employee Only	$41.12	$516.12	$81.12	$556.12	$170.62	$645.62
	Employee & Children Only	$256.36	$731.36	$296.36	$771.36	$434.83	$909.83
	Employee & Spouse Only	$448.04	$923.04	$488.04	$963.04	$665.95	$1,140.95
	Employee & Family	$650.04	$1,125.04	$690.04	$1,165.04	$911.86	$1,386.86
	***Dual Family	$175.04	$1,125.04	$215.04	$1,165.04	$436.86	$1,386.86

HMO PLAN: Employees will need to select a PCP for them and their dependents. Categories available are: Family Medice, OB/GYN, Pedicatrics & Geriatrics.

**Night Urgent Clinics: Cost may vary from $35.00 to $60.00 depending on service hours.

***Dual Family Plan is only for legally married couples (with children) who both are full time employees for UISD. Must contact Risk Management to