

COST AND BENEFIT COMPARISON FOR:

WEST CHICAGO ELEMENTARY SCHOOL DISTRICT 33

Current

	Blue Cross Blue Shield														
	PPO - Support Staff & Custodians			PPO - Teachers & Administrators			HMO IL		HMO BA		HSA				
	In Network	Out Network		In Network	Out Network		Participating Providers		Participating Providers		In Network	Out Network			
Individual Deductible	\$250	\$500		\$1,000	\$2,000		\$0		\$0		\$3,200	\$5,000			
Family Deductible	\$750	\$1,500		\$3,000	\$6,000		\$0		\$0		\$6,400	\$10,000			
Coinurance	90%	70%		80%	60%		100%		100%		Ded then 100%	Ded then 80%			
Ind. OOP (inc ded)	\$1,250	\$2,500		\$2,000	\$4,000		\$1,500		\$1,500		\$3,200	\$10,000			
Fam. OOP (inc ded)	\$3,750	\$7,500		\$6,000	\$12,000		\$3,000		\$3,000		\$6,400	\$20,000			
Inpatient Hospital Svcs	90%	70% after:		80%	60% after:		100%		100%		Ded then 100%	Ded then 80%			
Inpatient Hospital Ded	\$0	\$300 per Visit		\$0	\$300 per Visit		\$0		\$0		\$0	\$300 per Visit			
Preventive Services	\$10 Copay	70%		100%	60%		\$10 Copay		\$10 Copay		100%	Ded then 80%			
Physician Services	\$10 Copay	70%		\$20 Copay	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Specialist Services	\$10 Copay	70%		\$20 Copay	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Lab & X-Ray / Imaging	90%	70%		80%	60%		100%		100%		Ded then 100%	Ded then 80%			
Urgent Care	90%	70%		80%	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Emergency Room	\$50 Copay			\$75 Copay			\$50 Copay		\$50 Copay		Deductible then 100%				
Rx - In Network	\$15/\$30/\$50			\$15/\$30/\$50			\$15/\$30/\$50		\$15/\$30/\$50		Deductible then 100%				
Rx - Out Network	\$15/\$30/\$50 + 25%			\$15/\$30/\$50 + 25%			Not Covered		Not Covered		Deductible + 25%				
Specialty Rx	\$50 Copay	\$50 Copay + 25%		\$50 Copay	\$50 Copay + 25%		\$50 Copay		\$50 Copay		Ded then 100%	Ded + 25%			
Mail Order	2x / 90 Days	Not Covered		2x / 90 Days	Not Covered		2x / 90 Days		2x / 90 Days		Ded then 100%	Not Covered			
EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	
Employee:	11	\$959.24	\$10,551.64	60	\$949.65	\$56,979.00	43	\$815.34	\$35,059.62	58	\$796.17	\$46,177.86	22	\$844.12	\$18,570.64
Family:	22	\$2,168.00	\$47,696.00	61	\$2,146.32	\$130,925.52	52	\$1,842.80	\$95,825.60	132	\$1,799.45	\$237,527.40	17	\$1,907.84	\$32,433.28
Total per policy:	33		\$58,247.64	121		\$187,904.52	95		\$130,885.22	190		\$283,705.26	39		\$51,003.92
Total Monthly:	\$711,746.56														

Revised Renewal

	Blue Cross Blue Shield														
	PPO - Support Staff & Custodians			PPO - Teachers & Administrators			HMO IL		HMO BA		HSA				
	In Network	Out Network		In Network	Out Network		Participating Providers		Participating Providers		In Network	Out Network			
Individual Deductible	\$250	\$500		\$1,000	\$2,000		\$0		\$0		\$3,300	\$5,000			
Family Deductible	\$750	\$1,500		\$3,000	\$6,000		\$0		\$0		\$6,600	\$10,000			
Coinurance	90%	70%		80%	60%		100%		100%		Ded then 100%	Ded then 80%			
Ind. OOP (inc ded)	\$1,250	\$2,500		\$2,000	\$4,000		\$1,500		\$1,500		\$3,300	\$10,000			
Fam. OOP (inc ded)	\$3,750	\$7,500		\$6,000	\$12,000		\$3,000		\$3,000		\$6,600	\$20,000			
Inpatient Hospital Svcs	90%	70% after:		80%	60% after:		100%		100%		Ded then 100%	Ded then 80%			
Inpatient Hospital Ded	\$0	\$300 per Visit		\$0	\$300 per Visit		\$0		\$0		\$0	\$300 per Visit			
Preventive Services	\$10 Copay	70%		100%	60%		\$10 Copay		\$10 Copay		100%	Ded then 80%			
Physician Services	\$10 Copay	70%		\$20 Copay	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Specialist Services	\$10 Copay	70%		\$20 Copay	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Lab & X-Ray / Imaging	90%	70%		80%	60%		100%		100%		Ded then 100%	Ded then 80%			
Urgent Care	90%	70%		80%	60%		\$10 Copay		\$10 Copay		Ded then 100%	Ded then 80%			
Emergency Room	\$50 Copay			\$75 Copay			\$50 Copay		\$50 Copay		Deductible then 100%				
Rx - In Network	\$15/\$30/\$50			\$15/\$30/\$50			\$15/\$30/\$50		\$15/\$30/\$50		Deductible then 100%				
Rx - Out Network	\$15/\$30/\$50 + 25%			\$15/\$30/\$50 + 25%			Not Covered		Not Covered		Deductible + 25%				
Specialty Rx	\$50 Copay	\$50 Copay + 25%		\$50 Copay	\$50 Copay + 25%		\$50 Copay		\$50 Copay		Ded then 100%	Ded + 25%			
Mail Order	2x / 90 Days	Not Covered		2x / 90 Days	Not Covered		2x / 90 Days		2x / 90 Days		Ded then 100%	Not Covered			
EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	EE	RATE	TOTAL	
Employee:	11	\$997.13	\$10,968.43	60	\$987.16	\$59,229.60	43	\$847.54	\$36,444.22	58	\$828.66	\$48,062.28	22	\$877.44	\$19,303.68
Family:	22	\$2,253.63	\$49,579.86	61	\$2,231.10	\$136,097.10	52	\$1,915.59	\$99,610.68	132	\$1,870.53	\$246,909.96	17	\$1,983.20	\$33,714.40
Total Monthly:	33		\$60,548.29	121		\$195,326.70	95		\$136,054.90	190		\$294,972.24	39		\$53,018.08
Total Monthly:	\$739,920.21														

Current

Revised Renewal

Total Monthly:	\$711,746.56	\$739,920.21
Total Annually:	\$8,540,958.72	\$8,879,042.52
Annual Difference:	N/A	\$338,083.80
Percent Difference:	N/A	3.96%

THIS SUMMARY IS FOR ILLUSTRATION PURPOSES ONLY. BENEFITS & RATES PROVIDED BY THE CARRIER WILL PREVAIL.