LEWIS CASS ISD
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HEALTH INSURANCE COMPARISON

COVERAGE	AETNA MI18 OAMC 1000 100/80 Rx8VP		AETNA MI18 OAMC 1000 90/70 Rx8VP		AETNA MI18 OAMC 1500 80/60 Rx8VP	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible - (Individual / Family)	$1,000 / $2,000	$2,000 / $4,000	$1,000 / $2,000	$2,000 / $4,000	$1,500 / $3,000	$3,000 / $6,000
Co-Insurance	100%	80/20% of R&C	90/10%	70/30% of R&C	80/20%	60/40%
Co-Insurance Maximum	N/A	N/A	N/A	N/A	N/A	N/A
Total Out-of-Pocket (Ded, Coins. & Copays)	$1,500 / $3,000	$2,500 / $5,000	$1,500 / $3,000	$4,000 / $8,000	$2,500 / $5,000	$6,000 / $12,000
Primary Care Physician Office Visit Copay	$15 Copay	80% of R&C after deductible	$25 Copay	70% of R&C after deductible	$20 Copay	60% of R&C after deductible
Specialist Physician Office Visit Copay	$30 Copay	80% of R&C after deductible	$50 Copay	70% of R&C after deductible	$40 Copay	60% of R&C after deductible
Virtual Visit Copay	$15 Copay	Not Covered	$25 Copay	Not Covered	$20 Copay	Not Covered
Routine/Preventative Services	100%	80% of R&C after deductible	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Inpatient Treatment	100% after deductible	80% of R&C after deductible	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Urgent Care	$75 Copay	80% of R&C after deductible	$75 Copay	70% of R&C after deductible	$75 Copay	60% of R&C after deductible
ER Services	$150 Copay	$150 Copay	$150 Copay	$150 Copay	$150 Copay	$150 Copay
Emergency Ambulance Services	100% after deductible	100% after in-network deductible	90% after deductible	90% after in-network deductible	80% after deductible	80% after in-network deductible
Diagnostic X-Ray, Lab	100% after deductible	80% of R&C after deductible	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Advanced Imaging	100% after deductible	80% of R&C after deductible	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Rehabilitative Services (PT/OT)	$30 Copay 60 visit limit per calendar year combined	80% of R&C after deductible	$50 Copay 60 visit limit per calendar year combined	70% of R&C after deductible	$40 Copay 60 visit limit per calendar year combined	60% of R&C after deductible
Chiropractic/Manipulative Services	$30 Copay 20 visit limit per calendar year	80% of R&C after deductible	$50 Copay 20 visit limit per calendar year	70% of R&C after deductible	$40 Copay 20 visit limit per calendar year	60% of R&C after deductible
Durable Medical Equipment	100% after deductible	80% of R&C after deductible	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Prescriptions	$3 / $10 / $30 / $60 / 20% ($250 max) / 20% ($400 max)	30% of submitted cost after copay	$10/ $30 / $60 / 20% ($250 max) / 20% ($400 max)	30% of submitted cost after copay	$10/ $30 / $60 / 20%-$250 max / 20%-$400 max	30% of submitted cost after copay
Mail Order Prescriptions	2.5x Copay	Not Covered	2.5x Copay	Not Covered	2.5x Copay	Not Covered
Maternity						
Pre-Natal	100%	80% of R&C after deductible	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Post- *(Delivery - see Inpatient Treatment)*	$15 Copay	80% of R&C after deductible	$25 Copay	70% of R&C after deductible	$20 Copay	60% of R&C after deductible
Inpatient Mental Health Treatment	100% after deductible	80% of R&C after deductible	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Outpatient Mental Health Treatment	$30 Copay	80% of R&C after deductible	$50 Copay	70% of R&C after deductible	$40 Copay	60% of R&C after deductible
Network	Aetna Open Access POS		Aetna Open Access POS		Aetna Open Access POS	
Network Website	www.aetna.com		www.aetna.com		www.aetna.com	
Monthly Unit Health Rates	**Current**	**Renewal**	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
11 Employee	$752.71	$789.59	$739.23	$182.13	$701.40	$144.30
5 Employee & One	$1,691.45	$1,774.31	$1,661.18	$496.12	$1,576.16	$411.10
3 Family	$2,104.50	$2,207.60	$2,066.83	$547.47	$1,961.05	$441.69
19 Total Enrollment						
Approximate Medical Monthly Premium	**$23,050.56**	**$24,179.84**	**$22,637.92**		**$21,479.35**	
Approximate Medical Annual Premium	**$276,606.72**	**$290,158.08**	**$271,655.04**		**$257,752.20**	
Percentage Increase:		**4.9%**	**Percentage Increase:**	**-1.8%**	**Percentage Increase:**	**-6.8%**

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HEALTH INSURANCE COMPARISON

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COVERAGE	BLUE CROSS BLUE SHIELD Simply Blue $1,000 100%		UNITED HEALTHCARE		PRIORITY HEALTH	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible - (Individual / Family)	$1,000 / $2,000	$2,000 / $4,000	$1,000 / $2,000	$2,000 / $4,000	$1,000 / $2,000	$2,000 / $4,000
Co-Insurance	100%	80/20% of R&C	100%	80/20% of R&C	100%	80/20% of R&C
Co-Insurance Maximum	N/A	N/A	N/A	N/A	N/A	$2,500 / $5,000
Total Out-of-Pocket (Ded, Coins. & Copays)	$6,350 / $12,700	$12,700 / $25,400	$1,500 / $3,000	$2,500 / $5,000	$7,350 / $14,700	$14,700 / $29,400
Primary Care Physician Office Visit Copay	$30 Copay	80% of R&C after deductible	$15 Copay	80% of R&C after deductible	$15 Copay	80% of R&C after deductible
Specialist Physician Office Visit Copay	$50 Copay	80% of R&C after deductible	$30 Copay	80% of R&C after deductible	$30 Copay	80% of R&C after deductible
Virtual Visit Copay	$30 Copay	Not Covered	100%	Not Covered	100%	Not Covered
Routine/Preventative Services	100%	Not Covered	100%	Not Covered	100%	80% of R&C after deductible
Inpatient Treatment	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible
Urgent Care	$60 Copay	80% of R&C after deductible	$75 Copay	80% of R&C after deductible	$75 Copay	80% of R&C after deductible
ER Services	$250 Copay	$250 Copay	$150 Copay	$150 Copay	$150 Copay	$150 Copay
Emergency Ambulance Services	100% after deductible	100% after in-network deductible	100% after deductible	100% after deductible	$150 Copay	$150 Copay
Diagnostic X-Ray, Lab	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible
Advanced Imaging	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible	$150 Copay	80% of R&C after deductible
Rehabilitative Services (PT/OT)	100% after deductible 30 visit limit per calendar year combined	80% of R&C after deductible	$30 Copay 20 visit limit per calendar year	80% of R&C after deductible	$15 Copay 60 visit limit per calendar year combined	50% of R&C after deductible
Chiropractic/Manipulative Services	$30 Copay 12 visit limit per calendar year	80% of R&C after deductible	$30 Copay 20 visit limit per calendar year	80% of R&C after deductible	$15 Copay 24 visit limit per calendar year	50% of R&C after deductible
Durable Medical Equipment	100% after deductible	100% after in-network deductible	100% after deductible	80% of R&C after deductible	100% after deductible	50% of R&C after deductible
Prescriptions	$10 / $40 / $80 / 15%-$150 max / 25%-$300 max	Copay + 25%	$10 / $35/ $60		$10 / $30/ $60 / 20%-max $100 / 20%-max $200	
Mail Order Prescriptions	2x Copay	Not Covered	2.5x Copay	Not Covered	2x Copay	Not Covered
Maternity						
Pre-Natal	100%	80% of R&C after deductible	100%	80% of R&C after deductible	100%	80% of R&C after deductible
Post- *(Delivery - see Inpatient Treatment)*	100% after deductible	80% of R&C after deductible	100%	80% of R&C after deductible	100% after deductible	80% of R&C after deductible
Inpatient Mental Health Treatment	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible	100% after deductible	80% of R&C after deductible
Outpatient Mental Health Treatment	100% after deductible	80% of R&C after deductible	$30 Copay	80% of R&C after deductible	$15 Copay	80% of R&C after deductible
Network	Simply Blue PPO		United Healthcare		Priority Health POS	
Network Website	www.bcbsm.com		www.myuhc.com		www.priorityhealth.com	
Monthly Unit Health Rates	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
11 Employee	$695.55	$138.45	$781.05	$223.95	$813.45	$256.35
5 Employee & One	$1,669.32	$504.26	$1,757.36	$592.30	$1,827.99	$662.93
3 Family	$2,086.65	$567.29	$2,186.94	$667.58	$2,274.33	$754.97
19 Total Enrollment						
Approximate Medical Monthly Premium	**$22,257.60**		**$23,939.17**		**$24,910.89**	
Approximate Medical Annual Premium	**$267,091.20**		**$287,270.04**		**$298,930.68**	
Percentage Increase:	**-3.4%**		**3.9%**		**10.0%**	
	6.9% rate cap for 2020 renewal					

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HEALTH INSURANCE COMPARISON

COVERAGE	AETNA MI18 OAMC 3000 80/60 Rx8VP		AETNA MI18 OAMC 4000 70% Rx8VP		BLUE CROSS BLUE SHIELD Simply Blue PPO $3,000 80%	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible - (Individual / Family)	$3,000 / $6,000	$6,600 / $13,200	$4,000 / $8,000	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
Co-Insurance	80/20%	60/40% of R&C	70/30%	50/50% of R&C	80/20%	60/40% of R&C
Co-Insurance Maximum	N/A	N/A	N/A	N/A	$2,500 / $5,000	$5,000 / $10,000
Total Out-of-Pocket (Ded, Coins. & Copays)	$4,500 / $9,000	$12,000 / $24,000	$5,500 / $11,000	$16,000 / $32,000	$6,850 / $13,700	$13,700 / $27,400
Primary Care Physician Office Visit Copay	$30 Copay	60% of R&C after deductible	$25 Copay	50% of R&C after deductible	$30 Copay	60% of R&C after deductible
Specialist Physician Office Visit Copay	$60 Copay	60% of R&C after deductible	$50 Copay	50% of R&C after deductible	$50 Copay	60% of R&C after deductible
Virtual Visit Copay	$30 Copay	Not Covered	$25 Copay	Not Covered	$30 Copay	Not Covered
Routine/Preventative Services	100%	60% of R&C after deductible	100%	50% of R&C after deductible	100%	Not Covered
Inpatient Treatment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
Urgent Care	$75 Copay	60% of R&C after deductible	$75 Copay	50% of R&C after deductible	$60 Copay	60% of R&C after deductible
ER Services	$150 Copay	$150 Copay	$150 Copay	$150 Copay	$250 Copay	$250 Copay
Emergency Ambulance Services	80% after deductible	80% after in-network deductible	70% after deductible	70% after in-network deductible	80% after deductible	80% after in-network deductible
Diagnostic X-Ray, Lab	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
Advanced Imaging	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
Rehabilitative Services (PT/OT)	$60 Copay 60 visit limit per calendar year combined	60% of R&C after deductible	$50 Copay 60 visit limit per calendar year combined	50% of R&C after deductible	80% after deductible 30 visit limit per calendar year combined	60% of R&C after deductible
Chiropractic/Manipulative Services	$60 Copay 20 visit limit per calendar year	60% of R&C after deductible	$50 Copay 20 visit limit per calendar year	50% of R&C after deductible	$30 Copay 12 visit limit per calendar year	60% of R&C after deductible
Durable Medical Equipment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible	80% after deductible	80% after in-network deductible
Prescriptions	$3 / $10 / $30 / $60 / 20% ($250 max) / 20% ($400 max)	30% of submitted cost after copay	$10 / $30 / $60 / 20% ($250 max) / 20% ($400 max)	30% of submitted cost after copay	$10 / $40 / $80 / 15% ($150 max) / 25% ($300 max)	Copay + 25%
Mail Order Prescriptions	2.5x Copay	Not Covered	2.5x Copay	Not Covered	2x Copay	Not Covered
Maternity						
Pre-Natal	100%	60% of R&C after deductible	100%	50% of R&C after deductible	100%	60% of R&C after deductible
Post-	$30 Copay	60% of R&C after deductible	$25 Copay	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
(Delivery - see Inpatient Treatment)						
Inpatient Mental Health Treatment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
Outpatient Mental Health Treatment	$60 Copay	60% of R&C after deductible	$50 Copay	50% of R&C after deductible	80% after deductible	60% of R&C after deductible
Network	Aetna Open Access POS		Aetna Open Access POS		Simply Blue PPO	
Network Website	www.aetna.com		www.aetna.com		www.bcbsmi.com	
Monthly Unit Health Rates	**Current**	**Renewal**	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
16 Employee	$585.98	$614.69	$573.72	$16.62	$567.04	$9.94
8 Employee & One	$1,316.80	$1,381.31	$1,289.24	$124.18	$1,360.89	$195.83
13 Family	$1,638.35	$1,718.61	$1,604.06	$84.70	$1,701.11	$181.75
37 Total Enrollment						
Approximate Medical Monthly Premium	**$41,208.63**	**$43,227.45**	**$40,346.22**		**$42,074.19**	
Approximate Medical Annual Premium	**$494,503.56**	**$518,729.40**	**$484,154.64**		**$504,890.28**	
Percentage Increase:		**4.9%**	**Percentage Increase:**	**-2.1%**	**Percentage Increase:**	**2.1%**
						6.9% rate cap for 2020 renewal

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HEALTH INSURANCE COMPARISON

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COVERAGE	UNITED HEALTHCARE		PRIORITY HEALTH	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Deductible - (Individual / Family)	$3,000 / $6,000	$6,600 / $13,200	$3,000 / $6,000	$6,000 / $12,000
Co-Insurance	80/20%	60/40% of R&C	80/20%	60/40% of R&C
Co-Insurance Maximum	N/A	N/A	$1,500 / $3,000	$3,000 / $6,000
Total Out-of-Pocket (Ded, Coins. & Copays)	$4,500 / $9,000	$12,000 / $24,000	$7,350 / $14,700	$14,700 / $29,400
Primary Care Physician Office Visit Copay	$30 Copay	60% of R&C after deductible	$30 Copay	60% of R&C after deductible
Specialist Physician Office Visit Copay	$60 Copay	60% of R&C after deductible	$45 Copay	60% of R&C after deductible
Virtual Visit Copay	100%	Not Covered	100%	Not Covered
Routine/Preventative Services	100%	Not Covered	100%	60% of R&C after deductible
Inpatient Treatment	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Urgent Care	$75 Copay	60% of R&C after deductible	$75 Copay	60% of R&C after deductible
ER Services	$150 Copay	$150 Copay	$150 Copay	$150 Copay
Emergency Ambulance Services	80% after deductible	80% after in-network deductible	$150 Copay	$150 Copay
Diagnostic X-Ray, Lab	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Advanced Imaging	80% after deductible	60% of R&C after deductible	$150 Copay	60% of R&C after deductible
Rehabilitative Services (PT/OT)	$30 Copay	60% of R&C after deductible	$30 Copay	60% of R&C after deductible
	20 visit limit per calendar year		60 visit limit per calendar year combined	
Chiropractic/Manipulative Services	$30 Copay	60% of R&C after deductible	$30 Copay	60% of R&C after deductible
	20 visit limit per calendar year		24 visit limit per calendar year	
Durable Medical Equipment	80% after deductible	60% of R&C after deductible	80% after deductible	50% of R&C after deductible
Prescriptions	$10 / $35/ $60		$10 / $30/ $60 / 20%-max $100 / 20%-max $200	
Mail Order Prescriptions	2.5x Copay	Not Covered	2x Copay	Not Covered
Maternity				
Pre-Natal	100%	60% of R&C after deductible	100%	60% of R&C after deductible
Post-	100%	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
(Delivery - see Inpatient Treatment)				
Inpatient Mental Health Treatment	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Outpatient Mental Health Treatment	$30 Copay	60% of R&C after deductible	$30 Copay	60% of R&C after deductible
Network	United Healthcare		Priority Health POS	
Network Website	www.myuhc.com		www.priorityhealth.com	
Monthly Unit Health Rates	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
16 Employee	$633.20	$76.10	$628.43	$71.33
8 Employee & One	$1,424.70	$259.64	$1,412.21	$247.15
13 Family	$1,772.96	$253.60	$1,757.02	$237.66
37 Total Enrollment				
Approximate Medical Monthly Premium	**$44,577.28**		**$44,193.82**	
Approximate Medical Annual Premium	**$534,927.36**		**$530,325.84**	
NOTE: This benefit listing is only a general summary, it is not	**Percentage Increase:**	**8.2%**	**Percentage Increase:**	**7.2%**

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COVERAGE	AETNA MI18 OAMC 3000 90/70 HSA Rx15 VP		AETNA MI18 OAMC 3000 80/60 HSA Rx15 VP		BLUE CROSS BLUE SHIELD Simply Blue HSA $3,000 100%	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible - (Individual / Family)	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000
Co-Insurance	90/10%	70/30% of R&C	80/60%	60/40% of R&C	100/0%	80/20% of R&C
Co-Insurance Maximum	N/A	N/A	N/A	N/A	N/A	N/A
Total Out-of-Pocket (Ded, Coins. & Copays)	$4,000 / $8,000	$12,000 / $24,000	$4,000 / $8,000	$12,000 / $24,000	$6,350 / $12,700	$12,700 / $25,400
Primary Care Physician Office Visit Copay	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Specialist Physician Office Visit Copay	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Virtual Visit Copay	$40 Copay after deductible	Not Covered	$40 Copay after deductible	Not Covered	100% after deductible	Not Covered
Routine/Preventative Services	100%	70% of R&C after deductible	100%	60% of R&C after deductible	100%	Not Covered
Inpatient Treatment	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Urgent Care	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
ER Services	90% after deductible	90% of R&C after deductible	80% after deductible	80% of R&C after deductible	100% after deductible	100% after in-network deductible
Emergency Ambulance Services	90% after deductible	90% of R&C after deductible	80% after deductible	80% of R&C after deductible	100% after deductible	100% after in-network deductible
Diagnostic X-Ray, Lab	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Advanced Imaging	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Rehabilitative Services (PT/OT)	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
	60 visit limit per calendar year on each PT and OT		60 visit limit per calendar year on each PT and OT		30 visit limit per calendar year combined	
Chiropractic/Manipulative Services	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
	20 visit limit per calendar year		20 visit limit per calendar year		12 visit limit per calendar year	
Durable Medical Equipment	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	100% after in-network deductible
Prescriptions	Deductible, then $3 / $15 / $35 / $75 / $250 / $300 Copay	20% of submitted cost after deductible/copay	Deductible, then $15 / $35 / $75 / $250 / $300 Copay	20% of submitted cost after deductible/copay	Deductible, then $10 / $40 / $80 / 15% ($150 max) / 25% ($300 max)	Copay + 25% after deductible
Mail Order Prescriptions	Deductible, then 2.5x Copay	Not Covered	Deductible, then 2.5x Copay	Not Covered	Deductible, then 2x Copay	Not Covered
Maternity						
Pre-Natal	100%	70% of R&C after deductible	100%	60% of R&C after deductible	100%	80% of R&C after deductible
Post-	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
(Delivery - see Inpatient Treatment)						
Inpatient Mental Health Treatment	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Outpatient Mental Health Treatment	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible	100% after deductible	80% of R&C after deductible
Network	Aetna Open Access POS		Aetna Open Access POS		Simply Blue PPO	
Network Website	www.aetna.com		www.aetna.com		www.bcbsm.com	
Monthly Unit Health Rates	**Current**	**Renewal**	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
6 Employee	$545.37	$572.12	$552.28	-$4.82	$542.69	($14.41)
3 Employee & One	$1,225.54	$1,285.66	$1,241.06	$76.00	$1,302.45	$137.39
3 Family	$1,524.81	$1,599.61	$1,544.12	$24.76	$1,628.07	$108.71
12 Total Enrollment						
Approximate Medical Monthly Premium	**$11,523.27**	**$12,088.53**	**$11,669.22**		**$12,047.70**	
Approximate Medical Annual Premium	**$138,279.24**	**$145,062.36**	**$140,030.64**		**$144,572.40**	
Percentage Increase:		**4.9%**	**Percentage Increase:**	**1.3%**	**Percentage Increase:**	**4.6%**
						6.9% rate cap for 2020 renewal

NOTE: This benefit listing is only a general summary, it is

HEALTH INSURANCE COMPARISON

LEWIS CASS ISD
PRESENTED BY:

Rose Street ADVISORS
BENEFITS | INSURANCE | INVESTMENTS

ROSE STREET ADVISORS

COVERAGE	BLUE CROSS BLUE SHIELD Simply Blue HSA $3,000 80%		UNITED HEALTHCARE		PRIORITY HEALTH	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible - (Individual / Family)	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000
Co-Insurance	80/20%	60/40% of R&C	90/10%	70/30% of R&C	90/10%	70/30% of R&C
Co-Insurance Maximum	N/A	N/A	N/A	N/A	N/A	N/A
Total Out-of-Pocket (Ded, Coins. & Copays)	$6,350 / $12,700	$12,700 / $25,400	$4,000 / $8,000	$12,000 / $24,000	$4,000 / $8,000	$8,000 / $16,000
Primary Care Physician Office Visit Copay	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Specialist Physician Office Visit Copay	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Virtual Visit Copay	80% after deductible	Not Covered	90% after deductible	Not Covered	100% after deductible	Not Covered
Routine/Preventative Services	100%	Not Covered	100%	Not Covered	100%	70% of R&C after deductible
Inpatient Treatment	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Urgent Care	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
ER Services	80% after deductible	80% after in-network deductible	90% after deductible	90% after deductible	90% after deductible	90% of R&C after deductible
Emergency Ambulance Services	80% after deductible	80% after in-network deductible	90% after deductible	90% after deductible	90% after deductible	90% of R&C after deductible
Diagnostic X-Ray, Lab	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Advanced Imaging	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Rehabilitative Services (PT/OT)	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
	30 visit limit per calendar year combined		20 visit limit per calendar year		60 visit limit per calendar year on each PT and OT	
Chiropractic/Manipulative Services	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
	12 visit limit per calendar year		20 visit limit per calendar year		24 visit limit per calendar year	
Durable Medical Equipment	80% after deductible	80% after in-network deductible	90% after deductible	70% of R&C after deductible	90% after deductible	50% of R&C after deductible
Prescriptions	Deductible, then $10 / $40 / $80 / 15% ($150 max) / 25% ($300 max)	Copay + 25% after deductible	Deductible, then $10 / $35/ $60		Deductible, then $10 / $30/ $60 / 20%-max $100 / 20%-max $200	
Mail Order Prescriptions	Deductible, then 2x Copay	Not Covered	Deductible, then 2.5x Copay	Not Covered	Deductible, then 2x Copay	Not Covered
Maternity						
Pre-Natal	100%	60% of R&C after deductible	100%	70% of R&C after deductible	100%	70% of R&C after deductible
Post-	80% after deductible	60% of R&C after deductible	100%	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
(Delivery - see Inpatient Treatment)						
Inpatient Mental Health Treatment	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Outpatient Mental Health Treatment	80% after deductible	60% of R&C after deductible	90% after deductible	70% of R&C after deductible	90% after deductible	70% of R&C after deductible
Network	Simply Blue PPO		United Healthcare		Priority Health POS	
Network Website	www.bcbsm.com		www.myuhc.com		www.priorityhealth.com	
Monthly Unit Health Rates	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**	**Premium**	**Employee Monthly Rate after Hard Cap**
6 Employee	$494.18	($62.92)	$517.61	($39.49)	$505.73	($51.37)
3 Employee & One	$1,186.04	$20.98	$1,164.62	($0.44)	$1,136.48	($28.58)
3 Family	$1,482.55	($36.81)	$1,449.31	($70.05)	$1,413.97	($105.39)
12 Total Enrollment						
Approximate Medical Monthly Premium	**$10,970.85**		**$10,947.45**		**$10,685.73**	
Approximate Medical Annual Premium	**$131,650.20**		**$131,369.40**		**$128,228.76**	
Percentage Increase:		**-4.8%**	**Percentage Increase:**	**-5.0%**	**Percentage Increase:**	**-7.3%**
		6.9% rate cap for 2020 renewal				

NOTE: This benefit listing is only a general summary, it is

LEWIS CASS ISD

7/1/2019 Renewal Options - Medical Cost Summary

Current - Aetna Plans

	Single Deductible	Current Monthly Premium	Current Annual Premium	Renewal Monthly Premium	Renewal Annual Premium
High	$1,000	$23,050.56	$276,606.72	$24,179.84	$290,158.08
Mid	$3,000	$41,208.63	$494,503.56	$43,227.45	$518,729.40
HDHP	$3,000	$11,523.27	$138,279.24	$12,088.53	$145,062.36
		Annual Costs	**$909,389.52**	**Annual Costs**	**$953,949.84**
				Premium Change	**$44,560.32**
				Percentage Change	**4.90%**

Option #1 - Aetna

		Monthly Premium	Annual Premium		
High	$1,500	$21,479.35	$257,752.20		
Mid	$4,000	$40,346.22	$484,154.64		
HDHP	$3,000	$11,669.22	$140,030.64	Premium Change	-$27,452.04
		Total Annual Cost	$881,937.48	Percentage Change	-3.02%

Option #2 - BCBSM

		Monthly Premium	Annual Premium		
High	$1,000	$22,257.60	$267,091.20		
Mid	$3,000	$42,074.19	$504,890.28		
HDHP	$3,000/100%	$12,047.70	$144,572.40	*Premium Change	$7,164.36
		Total Annual Cost	$916,553.88	Percentage Change	0.79%

Option #3 - UHC

		Monthly Premium	Annual Premium		
High	$1,000	$23,939.17	$287,270.04		
Mid	$3,000	$44,577.28	$534,927.36		
HDHP	$3,000	$10,947.45	$131,369.40	Premium Change	$44,177.28
		Total Annual Cost	$953,566.80	Percentage Change	4.86%

Option #4 - Priority Health

		Monthly Premium	Annual Premium		
High	$1,000	$24,910.89	$298,930.68		
Mid	$3,000	$44,193.82	$530,325.84		
HDHP	$3,000	$10,685.73	$128,228.76	Premium Change	$48,095.76
		Total Annual Cost	$957,485.28	Percentage Change	5.29%