CITY OF ST. CHARLES SCHOOL DISTRICT
HEALTH INSURANCE COMPARISON
EFFECTIVE JANUARY 1, 2017

FEATURES:	ANTHEM BCBS					
	Lumenos H.S.A		Base Plan		Premium Plan	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Individual Deductible:	$2,000	$2,000	$500	$1,000	$300	$500
Family Deductible:	$4,000	$4,000	$1,000	$2,000	$600	$1,000
Co-Insurance:	100%	70%	**90%**	60%	100%	70%
Out of Pocket Maximum: (Incl. Ded.)						
Individual:	$2,000	$4,000	$2,500	$5,000	$1,750	$3,500
Family:	$4,000	$8,000	$5,000	$10,000	$3,500	$7,000
Office Care						
The Bridge Health Center	***$35.00***		***$0 Cost to Member***		***$0 Cost to Member***	
Office Visits PCP:	Deductible &	Deductible &	$35 Co-Pay	Deductible &	$30 Co-Pay	Deductible &
Specialist	Coinsurance	Coinsurance	$50 Co-Pay	Coinsurance	$40 Co-Pay	Coinsurance
Preventive Care (via healthcare reform)	100%		100%		100%	
Outpatient Lab Work						
The Bridge Health Center	***$35.00***		***$0 Cost to Member***		***$0 Cost to Member***	
Office Setting/Free Standing Lab:	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance or Copay	Deductible & Coins.
Outpatient and Inpatient Hospital & X-R	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Acute Care						
The Bridge Health Center	***$35.00***		***$0 Cost to Member***		***$0 Cost to Member***	
Urgent Care	Deductible & Coinsurance		$125 Co-Pay	Ded & Coins.	$100 Co-Pay	Ded & Coins.
Emergency Room: (True Emergency)	Deductible & Coinsurance		$200 Co-Pay Waived if Admitted		$150 Co-Pay Waived if Admitted	
Prescription Drug Coverage:	Deductible & Coinsurance		$100 Ded, then $10/$30/$70 at Participating Pharmacies Separate $4,000.00 OOP Max		$10/$25/$50 Co-Pay at Participating Pharmacies Separate $4,000.00 OOP Max	
Mail Order Drug Coverage:	Deductible & Coinsurance	Not Covered	$100 Ded, 2 x Co-Pay for a 90 Day Supply	Not Covered	2 x Co-Pay for a 90 Day Supply	Not Covered
District Contribution to H.S.A.	***$1500/yr.-$500/Jan.5th-March 5th-Sept.5th***		n/a		n/a	
MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK	**H.S.A Plan**		**Base Plan**		**Premium Plan**	
*Individual Only**	$550.00*		$610.00*		$693.00*	
Spouse	$392.00		$412.00		$667.00	
Child(ren)	$289.00		$312.00		$537.00	
Family	$692.00		$737.00		$1,197.00	

***District continues to pay the individual portion.** (The above illustration is an outline of the plan's coverage not to be used to determine if claims are eligible for payment.)

****The District offers employees to waive participation in the Medical benefit plan if provided with documentation that you are covered under another group medical plan. In lieu of participation in the medical benefit plan, the employee will receive $100 per pay stipend-ask for details. The above outline is for illustration purposes only.**