CITY OF ST. CHARLES SCHOOL DISTRICT HEALTH INSURANCE COMPARISON EFFECTIVE JANUARY 1, 2019

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FEATURES:	UMR - UnitedHealth Choice Plus PPO/Optum Rx						
	H.S.A		Base Plan		Premium Plan		
		Out of Network	In Network	Out of Network	In Network	Out of Network	
Individual Deductible:	\$2,000	\$2,000	\$600	\$1,200	\$400	\$800	
Family Deductible:	\$4,000	\$4,000	\$1,200	\$2,400	\$800	\$1,600	
Co-Insurance:	100%	70%	90%	60%	100%	70%	
Out of Pocket Maximum: (Incl. Ded.)							
Individual:	\$2,000	\$4,000	\$2,600	\$5,200	\$2,000	\$4,000	
Family:	\$4,000	\$8,000	\$5,200	\$10,400	\$4,000	\$8,000	
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Office Care							
The Bridge Health Center	\$35.00		\$0 Cost to Member		\$0 Cost to Member		
Office Visits PCP:	Deductible &	Deductible &	\$40 Co-Pay	Deductible &	\$35 Co-Pay	Deductible &	
Specialist	Coinsurance	Coinsurance	\$50 Co-Pay	Coinsurance	\$40 Co-Pay	Coinsurance	
*		Comsurance	•	Comsurance	_	Comsurance	
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		
					Deductible & Coins.		
Office Setting/Free Standing Lab:	Deductible & Coinsurance		Deductible & Coinsurance		Coinsurance or Copay		
					1		
Outpatient and Inpatient Hospital & X-1	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 & C	Coinsurance	\$150 Co-Pay	Ded & Coins.	\$125 Co-Pay	Ded & Coins.	
Emergency Room:	Deductible & Coinsurance		\$250 Co-Pay		\$200 Co-Pay		
(True Emergency)		beductible & Comsurance		Waived if Admitted		Waived if Admitted	
(True Emergency)			vvarved ir r	Idilitica	Walved II 1	idilitiod	
Presentation Drug Coverage	Deductible & Coinsurance		\$150 Dad than		\$10/\$25/\$50 Co-Pay at		
Prescription Drug Coverage:	Daduatible & C	Toingunga a	\$150 Dag	l than	\$10/\$25/\$50	Co Dov. et	
	Deductible & C	Coinsurance	\$150 Dec				
	Deductible & C	Coinsurance	\$10/\$30/	\$70 at	Participating 1	Pharmacies	
	Deductible & (Coinsurance	\$10/\$30/ Participating I	\$70 at Pharmacies		Pharmacies	
	Deductible & (Coinsurance	\$10/\$30/	\$70 at Pharmacies	Participating 1	Pharmacies	
	Deductible & C	Coinsurance	\$10/\$30/ Participating I	\$70 at Pharmacies	Participating 1	Pharmacies	
Mail Order Drug Coverage:	Deductible & C	Coinsurance Not Covered	\$10/\$30/ Participating I	\$70 at Pharmacies 00 OOP Max	Participating 1	Pharmacies	
Mail Order Drug Coverage:			\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay	\$70 at Pharmacies 00 OOP Max	Participating I Separate \$4,000. 2 x Co-Pay	Pharmacies 00 OOP Max	
Mail Order Drug Coverage:	Deductible &		\$10/\$30/ Participating I Separate \$4,000.	\$70 at Pharmacies 00 OOP Max	Participating l Separate \$4,000.	Pharmacies 00 OOP Max	
Mail Order Drug Coverage: District Contribution to H.S.A.	Deductible &	Not Covered	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay	\$70 at Pharmacies .00 OOP Max Not Covered	Participating I Separate \$4,000. 2 x Co-Pay	Pharmacies 00 OOP Max Not Covered	
	Deductible & Coinsurance	Not Covered March 5th-Sept.5th	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply	\$70 at Pharmacies 00 OOP Max Not Covered	Participating 1 Separate \$4,000. 2 x Co-Pay for a 90 Day Supply	Pharmacies 00 OOP Max Not Covered	
District Contribution to H.S.A.	Deductible & Coinsurance \$1500/yr\$500/Jan.5th-l	Not Covered March 5th-Sept.5th	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply	\$70 at Pharmacies 00 OOP Max Not Covered	Participating I Separate \$4,000. 2 x Co-Pay for a 90 Day Supply	Pharmacies 00 OOP Max Not Covered	
District Contribution to H.S.A. MONTHLY AMT WITHELD FROM	Deductible & Coinsurance \$1500/yr\$500/Jan.5th-l	Not Covered March 5th-Sept.5th Plan	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply	\$70 at Pharmacies 00 OOP Max Not Covered	Participating I Separate \$4,000. 2 x Co-Pay for a 90 Day Supply	Pharmacies 00 OOP Max Not Covered	
District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK	Deductible & Coinsurance \$1500/yr\$500/Jan.5th-I	Not Covered March 5th-Sept.5th Plan 00*	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply n/a Base F	\$70 at Pharmacies 00 OOP Max Not Covered Plan 00*	Participating I Separate \$4,000. 2 x Co-Pay for a 90 Day Supply n/a <u>Premiun</u>	Pharmacies 00 OOP Max Not Covered Plan 00*	
District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK Individual Only* Spouse	Deductible & Coinsurance \$1500/yr\$500/Jan.5th-1 H.S.A 1	Not Covered March 5th-Sept.5th Plan 00*	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply n/a Base F	\$70 at Pharmacies 00 OOP Max Not Covered Plan 00* 00	Participating I Separate \$4,000. 2 x Co-Pay for a 90 Day Supply n/a Premium \$768.0	Pharmacies 00 OOP Max Not Covered Pharmacies Not Covered	
District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK Individual Only*	Deductible & Coinsurance \$1500/yr\$500/Jan.5th-1 H.S.A 1 \$639.0 \$413.	Not Covered March 5th-Sept.5th Plan 00* 00 00	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply n/a Base F	\$70 at Pharmacies 00 OOP Max Not Covered Plan 00* 00 00	Participating I Separate \$4,000. 2 x Co-Pay for a 90 Day Supply n/a Premium \$768.0 \$722.	Pharmacies 00 OOP Max Not Covered Plan 00* 00 00	

^{**}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.