CITY OF ST. CHARLES SCHOOL DISTRICT HEALTH INSURANCE COMPARISON EFFECTIVE JANUARY 1, 2020

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FEATURES:	UMR - UnitedHealth Choice Plus PPO/Optum Rx					
	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	\$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.)	1					
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	ı					
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	1					
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.
	Boddenoie & Comparance				1.7	
Outpatient and Inpatient Hospital & X-l	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Acute Care	1					
The Bridge Health Center	\$35.00		\$0 Cost to Member		\$0 Cost to Member	
Urgent Care	Deductible &		\$150 Co-Pay	Ded & Coins.	\$125 Co-Pay	Ded & Coins.
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Emergency Room:	Deductible &	Coinsurance	\$250 Co-Pay		\$200 Co-Pay	
(True Emergency)	1	ļ	Waived if Admitted		Waived if Admitted	
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Properintion Drug Coverage:	Doductible &	Coincurance	\$150 Do	l than	\$10/\$25/\$50	Co. Pay at
Prescription Drug Coverage:	Deductible &	Coinsurance	\$150 Dec		\$10/\$25/\$50	
Prescription Drug Coverage:	Deductible &	Coinsurance	\$10/\$30/	\$70 at	Participating 1	Pharmacies
Prescription Drug Coverage:	Deductible &	Coinsurance	\$10/\$30/ Participating l	\$70 at Pharmacies		Pharmacies
Prescription Drug Coverage:	Deductible &	Coinsurance	\$10/\$30/	\$70 at Pharmacies	Participating 1	Pharmacies
			\$10/\$30/ Participating I Separate \$4,000.	\$70 at Pharmacies 00 OOP Max	Participating l Separate \$4,000.	Pharmacies 00 OOP Max
	Deductible &	Coinsurance Not Covered	\$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
Prescription Drug Coverage: Mail Order Drug Coverage:			\$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:	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
Mail Order Drug Coverage:	Deductible & Coinsurance \$1500/yr\$500/Jan.5th	Not Covered n-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
Mail Order Drug Coverage: District Contribution to H.S.A.	Deductible & Coinsurance	Not Covered n-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
Mail Order Drug Coverage: District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK	Deductible & Coinsurance \$1500/yr\$500/Jan.5th	Not Covered 1-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
Mail Order Drug Coverage: District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK Individual Only*	Deductible & Coinsurance \$1500/yr\$500/Jan.5th H.S.A \$639	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 I	\$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 Premium \$768.0	Pharmacies 00 OOP Max Not Covered 1 Plan 00*
Mail Order Drug Coverage: District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK Individual Only* Spouse	Deductible & Coinsurance \$1500/yr\$500/Jan.5th H.S.A \$639 \$413	Not Covered March 5th-Sept.5th Plan 00* 3.00	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply n/a Base I \$675.0 \$452.	\$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 \$722.	Pharmacies 00 OOP Max Not Covered 1 Plan 00* 00
Mail Order Drug Coverage: District Contribution to H.S.A. MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK Individual Only*	Deductible & Coinsurance \$1500/yr\$500/Jan.5th H.S.A \$639	Not Covered March 5th-Sept.5th Plan 00* 3.00 3.00	\$10/\$30/ Participating I Separate \$4,000. \$150 Ded, 2 x Co-Pay for a 90 Day Supply n/a Base I	\$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	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.