Boyne Falls Schools
Proposal Comparison

	Current **Carrier: Blue Cross Blue Shield** Plan Name: SB H.S.A PPO Gold $1750*		**Option 1** **Carrier: Priority** Plan Name: HMO H.S.A Silver $2000		**Option 2** **Carrier: Blue Care Network** Plan Name: HMO H.S.A Silver $2000	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Effective Date	12/1/2014		12/1/2014		12/1/2014	
Deductible						
Individual	$1,750	$3,500	$2,000	N/A	$2,000	N/A
Couple/Family	$3,500	$7,000	$4,000	N/A	$4,000	N/A
Coinsurance	100%	80%	70%	N/A	80%	N/A
Annual Out of Pocket Max						
Individual	$6,350	$12,700	$4,000	N/A	$5,400	N/A
Couple/Family	$12,700	$25,400	$8,000	N/A	$10,800	N/A
Routine Services						
Preventive Care	Covered-100%	N/A	Covered-100%	N/A	Covered-100%	N/A
Office Visit	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Specialty Office Visit	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Hospital Services						
Urgent Care	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Emergency Room	Covered-100% after Ded		30% after Ded		20% after Ded	
Inpatient Hospital	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Outpatient Hospital	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Diagnostic Services						
Labs/X-Rays	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Imaging/CT/PET/MRI	Covered-100% after Ded	20% after Ded	30% after Ded	N/A	20% after Ded	N/A
Prescription Drugs						
Generic	$15 after Ded	$15+20% after Ded	$20 after Ded	N/A	$4/$15 after Ded	N/A
Preferred Brand	$50 after Ded	$50+20% after Ded	$60 after Ded	N/A	$40 after Ded	N/A
Non-Preferred Brand	50%/$100 after Ded	50%/$100 Max+20% after Ded	$80 after Ded	N/A	$80 after Ded	N/A
Specialty	20%/$300 Max after Ded	N/A	20%/$400 Max after Ded	N/A	20%/$300 Max after Ded	N/A
Mail-Order	Yes	N/A	Yes	N/A	Yes	N/A
Pediatric Vision	Yes	Yes	Yes	No	Yes	Yes
Pediatric Dental	Yes	No	No	No	No	Yes
Estimated Monthly Premium	$3,423.88		$2,684.01		$2,932.48	
Estimated Annual Premium	$41,086.56		$32,208.12		$35,189.76	

***Requires $250 Employer Contribution**

Note: **Illustrative Purposes Only**

The rates are subject to the carrier approval and underwriting.

Please refer to specific plan designs and benefit summary for more detailed benefit coverage.