



**Ovid Elsie Area Schools**  
**HEALTH BENEFIT/COST ANALYSIS**  
**2024 Options**

		Renewal BCBSM 7/1/2024-6/30/2025		BCN Option 1 7/1/2024-6/30/2025		BCN Option 2 7/1/2024-6/30/2025		BCBS Option 3 7/1/2024-6/30/2025		BCBS Option 4 7/1/2024-6/30/2025		MESSA 7/1/2024-12/31/2025	
<b>Plan Name</b>		Simply Blue PPO HSA		Blue Elect Plus HSA \$1600 0%		Blue Elect Plus HSA \$2000 0%		Simply Blue PPO HSA		Simply Blue PPO HSA		ABC 1	
<b>Provider Network</b>		PPO		POS		POS		PPO		PPO		PPO	
		<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Single Deductible</b>		\$1,600	\$3,200	\$1,600	\$3,200	\$2,000	\$4,000	\$2,000	\$4,000	\$3,200	\$6,400	\$1,600	\$3,200
<b>Family Deductible</b>		\$3,200	\$6,400	\$3,200	\$6,400	\$4,000	\$8,000	\$4,000	\$8,000	\$6,400	\$12,800	\$3,200	\$6,400
<b>Coinsurance</b>		0%	20%	0%	20%	0%	20%	0%	20%	0%	20%	0%	20%
<b>Single Out of Pocket Max</b>		\$4,000	\$8,000	\$4,000	\$8,000	\$4,000	\$8,000	\$4,000	\$8,000	\$6,900	\$13,800	\$3,600	\$7,200
<b>Family Out of Pocket Max</b>		\$8,000	\$16,000	\$8,000	\$16,000	\$7,500	\$15,000	\$8,000	\$16,000	\$13,800	\$27,600	\$7,200	\$14,400
<b>Office Visits</b>		Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	N/A	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then applicable coinsurance	Deductible, then applicable coinsurance
<b>Urgent Care</b>		Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	Deductible, then fully covered	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then fully covered	Deductible, then 20% Coinsurance	Deductible, then applicable coinsurance	Deductible, then applicable coinsurance
<b>Emergency Room</b>		Deductible, then fully covered		Deductible, then fully covered		Deductible, then fully covered		Deductible, then fully covered		Deductible, then fully covered		Deductible, then applicable coinsurance	
<b>Retail</b>		\$10/\$40/\$80 after deductible	\$10/\$40/\$80, plus 20% of approved amount after deductible	\$4/\$15/\$40/\$80/20%/20% after deductible	N/A	\$4/\$15/\$40/\$80/20%/20% after deductible	N/A	\$10/\$40/\$80 after deductible	\$10/\$40/\$80, plus 20% of approved amount after deductible	\$10/\$40/\$80 after deductible	\$10/\$40/\$80, plus 20% of approved amount after deductible	3-Tier Rx	In Network Copay plus 25% of approved amount
		<b>Renewal</b>		<b>Rates</b>		<b>Rates</b>		<b>Rates</b>		<b>Rates</b>		<b>Rates</b>	
Single	17	\$674.80		17	\$425.72	17	\$406.32	17	\$630.52	17	\$544.49	17	\$733.68
Double	12	\$1,619.52		12	\$1,021.71	12	\$975.16	12	\$1,513.24	12	\$1,306.78	12	\$1,650.77
Family	61	\$2,024.39		61	\$1,277.14	61	\$1,218.95	61	\$1,891.54	61	\$1,633.48	61	\$2,054.29
<b>Monthly Premium</b>		\$154,393.63			\$97,403.30		\$92,965.31		\$144,261.66		\$124,579.97		\$157,593.41
<b>Annual Premium</b>		\$1,852,723.56			\$1,168,839.60		\$1,115,583.72		\$1,731,139.92		\$1,494,959.64		\$1,891,120.88
<b>Monthly Cost to Hard Cap</b>													
Single		\$32.90			(\$216.18)		(\$235.58)		(\$11.38)		(\$97.41)		\$91.77
Double		\$277.10			(\$320.71)		(\$367.26)		\$170.82		(\$35.64)		\$308.35
Family		\$273.74			(\$473.51)		(\$531.70)		\$140.89		(\$117.17)		\$303.64

This comparison is intended to illustrate the carrier's proposed services and rates and should not be relied upon to fully determine benefits and rates. Refer to carrier's renewal/proposal for a complete representation of coverage terms and conditions.