

**CITY OF ST. CHARLES SCHOOL DISTRICT
HEALTH INSURANCE COMPARISON
EFFECTIVE October 1, 2009**

FEATURES:	Lumenos H.S.A - 6		Base Plan		Premium Plan	
	<u>In Network</u>	<u>Out of Network</u>	<u>In Network</u>	<u>Out of Network</u>	<u>In Network</u>	<u>Out of Network</u>
Individual Deductible:	\$2,000	\$2,000	\$500	\$1,000	\$0	\$300
Family Deductible:	\$4,000	\$4,000	\$1,000	\$2,000	\$0	\$600
Co-Insurance:	100%	70%	80%	60%	100%	70%
Out of Pocket Maximum: (Incl. Ded.)						
Individual:	\$2,000	\$4,000	\$2,500	\$5,000	\$0	\$3,000
Family:	\$4,000	\$8,000	\$5,000	\$10,000	\$0	\$6,000
Lifetime Maximum Benefit:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits PCP:(Preventive Care)	Ded. & Coins. PCP 100% No Ded.	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$20 Co-Pay	Deductible & Coinsurance
Specialist	Ded. & Coins.	Ded.& Coins.	Ded.& Coins.	Ded. & Coins.	\$30 Co-Pay	Ded. & Coins.
Outpatient Lab & X-Ray:	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	100%	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	100%	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	100%	Deductible & Coinsurance
Emergency Room: (True Emergency)	Deductible & Coinsurance	Deductible & Coinsurance	\$150 Co-Pay Waived if Admitted		\$100 Co-Pay Waived if Admitted	
Prescription Drug Coverage: Retail	Deductible & Coinsurance	Deductible & Coinsurance	\$100 Ded, then \$10/30/70 CoPay at Participating Pharmacies	\$100 Deductible then 50% (\$45 Min)	\$5/\$25/\$50	50% (\$45 Min.)
Mail Order Drug Coverage:	Deductible & Coinsurance	Not Covered	\$100 Ded, then \$20/60/140 for a 90 Day Supply	Not Covered	\$10/\$50/\$100 90 Day Supply	Not Covered
<i>District Contribution to H.S.A.</i>	<i>\$125 / Month</i>		n/a		n/a	
<u>MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK</u>	<u>H.S.A Plan</u>		<u>Base Plan</u>		<u>Premium Plan</u>	
<i>Individual Only*</i>	383.58*		423.26*		529.08*	
<i>Spouse</i>	\$401.44		\$359.78		\$581.98	
<i>Child(ren)</i>	\$324.72		\$275.12		\$476.08	
<i>Family</i>	\$708.30		\$698.38		\$1,005.24	

*District continues to pay the individual portion

The above outline is for illustration purposes only. It is not intended to provide specific definitions of the plan's coverage or to determine if specific claims are eligible for payment.