CITY OF ST. CHARLES SCHOOL DISTRICT
HEALTH INSURANCE COMPARISON
EFFECTIVE JANUARY 1, 2012

FEATURES:	Lumenos H.S.A - 6		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	$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:	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	$20 Co-Pay	Deductible & Coinsurance
Specialist					$30 Co-Pay	
Preventive Care (via healthcare reform)	100%		100%		100%	
Outpatient Lab & X-Ray:	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	100%	Deductible & Coinsurance
Outpatient Hospital	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:	Deductible & Coinsurance	Deductible & Coinsurance	$100 Ded, then $10/$30/$70 at Participating Pharmacies	$100 deductible 50% (min $45)	$5/$25/$50 Co-Pay at Participating Pharmacies	$100 deductible 50% (min $45)
Mail Order Drug Coverage:	Deductible & Coinsurance	Not Covered	$100 Ded, $20/$60/$140 for a 90 Day Supply	Not Covered	$10/$50/$100 Co-Pay for a 90 Day Supply	Not Covered
District Contribution to H.S.A.	***$125 / Month***		n/a		n/a	

MONTHLY AMT WITHELD FROM EMPLOYEE'S CHECK	H.S.A Plan	Base Plan	Premium Plan
*Individual Only**	$406.00*	$448.00*	$560.00*
Spouse	$417.60	$380.80	$616.00
Child(ren)	$336.40	$291.18	$504.00
Family	$742.38	$739.18	$1,064.00

***District continues to pay the individual portion.** (The above illustration is an outline of the plan's coverage not to be used to determine if claims are eligible for payment.)

****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.