ATTACHMENT NO. X-D:	Health Insurance Renewal
Potential motion:	Move to approve the renewal of Blue Cross Blue Shield (Health), Dearborn National (Life), Delta Dental (Dental) and Delta Vision (Vision) as provided by Arthur J. Gallagher & Co.
Recommended action:	Approve the motion

It is recommended that the Board approve the renewal of the Health/Life/Dental/Vision Insurance as proposed and provided by Arthur J. Gallagher & Co. The health care renewal proposal has a -5.2% decrease in premiums. The renewal has a $2500 deductible and will continue to offer a health reimbursement account to offset the difference in the deductible. Dental Insurance with Delta and vision insurance will remain the same as last year and they have offered a two year rate lock. Our life insurance quote increase by $450 for the year

The insurance committee includes certified staff, support staff, administration and broker representatives. The committee met and discussed the renewals of BCBS, Delta Dental and Dearborn Life. The committee decided to recommend to move forward with the renewal rates listed above.

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NORTH BOONE CUSD #200

Medical Rates & Benefits Comparison

EFFECTIVE DATE: JULY 1, 2020

PLAN STATUS	CURRENT		RENEWAL	
CARRIER(S)	Blue Cross Blue Shield		Blue Cross Blue Shield	
PLAN(S)	PPO 80% / 60%; $2,500 D; $30 OV		PPO 80% / 60%; $2,500 D; $30 OV	
NETWORK(S)	BluePrint PPO (MPPC3836)		BluePrint PPO (MPPC3836)	
PLAN BENEFITS	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Coinsurance Level	80%	60%	80%	60%
Individual Deductible	$2,500	$5,000	$2,500	$5,000
Family Deductible	$7,500	$15,000	$7,500	$15,000
Medical Individual Out-of-Pocket	$4,500	$9,000	$4,500	$9,000
Medical Family Out-of-Pocket	$10,200	$20,400	$10,200	$20,400
Does Medical OOP include RX Copays (Y/N)?	No		No	
Does OOP include Ded, Coins & Copays (Y/N)?	Yes		Yes	
MEDICAL SERVICES				
Office Visits PCP/SPC	$30 / $50 copay per visit	40% after ded	$30 / $50 copay per visit	40% after ded
Preventive Care	100% (no copay)	40% after ded	100% (no copay)	40% after ded
Diagnostic Test (X-Ray, Blood Work)	$30 PCP/$50 SPC	40% after ded	$30 PCP/$50 SPC	40% after ded
Imaging (CT/PET scans, MRIs)	20% after ded	40% after ded	20% after ded	40% after ded
Outpatient Surgery	20% after ded	40% after ded	20% after ded	40% after ded
Emergency Care *(waived if admitted)*	$150 then 100%		$150 then 100%	
Inpatient Hospital *(per occurrence)*	20% after ded	$300 plus 40%	20% after ded	$300 plus 40%
PRESCRIPTION DRUGS ‡				
Out-of-Pocket Maximum *(Individual / Family)*	$1,000 Individual / $3,000 Family		$1,000 Individual / $3,000 Family	
Tier 1	$10	25% after copay	$10	25% after copay
Tier 2	$40	25% after copay	$40	25% after copay
Tier 3	$60	25% after copay	$60	25% after copay
Tier 4	Covered	Covered	Covered	Covered
Tier 5	N/A	N/A	N/A	N/A
Mail Order Prescriptions *(90 Days)*	2x Copay	N/A	2x Copay	N/A
MONTHLY RATES				
Employee	$678.54		**$643.26**	
Employee & Spouse	$1,450.69		**$1,375.25**	
Employee & Child(ren)	$1,323.62		**$1,254.79**	
Family	$2,097.03		**$1,987.98**	
ESTIMATED ENROLLMENTS				
Employee	127		127	
Employee & Spouse	10		10	
Employee & Child(ren)	6		6	
Family	13		13	
PREMIUM				
Monthly Premium by Plan	$135,884.59		$128,819.00	
Monthly Premium	$135,884.59		$128,819.00	
Annual Premium	$1,630,615.08		$1,545,828.00	
Percentage Premium Difference	N/A		**-5.2%**	
Annual Premium Difference	N/A		**-$84,787.08**	
Rate Guarantee	1 Year		1 Year	
COMMISSION & COMPENSATION				
Commission Level	3.5% Flat		3.5% Flat	
Supplemental Compensation	$0 to $12 PEPY		$0 to $12 PEPY	

The analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

While AJG does not guarantee the financial viability of any health/dental insurance carrier or market, it is an area we recommend that clients closely scrutinize when selecting a health insurance carrier or HMO. There are a number of rating agencies that can be referred to including, A.M. Best, Fitch, Moody's, Standard & Poor's, and Weiss Ratings (TheStreet.com). Generally, agencies that provide ratings of U.S. Health Insurers, including traditional insurance companies and other managed care (e.g. HMO) organizations, reflect their opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. However, these ratings are not a warranty of an insurer's current or future ability to meet its contractual obligations.

‡ For Members purchasing Prescriptions from a Non-Network Pharmacy there may be an additional charge.

***Entire family deductible must be met before any one is eligible for coverage.**

Optional carrier rates are subject to final underwriting.

Commissions are based on a flat fee, per member or graded scale. These graded scales are available upon request. A Revenue Disclosure will be sent disclosing revenue for all lines annually.

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NORTH BOONE CUSD #200
Dental Rates & Benefits Comparison

EFFECTIVE DATE: JULY 1, 2020

PLAN STATUS	CURRENT			RENEWAL		
CARRIER(S)	Delta Dental of Illinois			Delta Dental of Illinois		
PLAN(S)	PPO 100/80/50/50			PPO 100/80/50/50		
NETWORK(S)	Delta Dental PPO Plus Premier			Delta Dental PPO Plus Premier		
PLAN BENEFITS	**PPO Dentist**	**Premier Dentist**	**Out-Network**	**PPO Dentist**	**Premier Dentist**	**Out-Network**
Deductible *(Individual / Family)*	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximums	$1,200	$1,200	$1,200	$1,200	$1,200	$1,200
CLASS I - Preventive	100%	100%	90%	100%	100%	90%
CLASS II - Basic	80%	80%	70%	80%	80%	70%
CLASS III - Major	50%	50%	40%	50%	50%	40%
CLASS IV - Ortho	50%			50%		
Lifetime Maximums	$1,000			$1,000		
COVERED SERVICES						
Endodontics	80%	80%	70%	80%	80%	70%
Periodontics - Non-Surgical	80%	80%	70%	80%	80%	70%
Periodontics - Surgical	50%	50%	40%	50%	50%	40%
Simple Extractions	80%	80%	70%	80%	80%	70%
Implants	50%	50%	40%	50%	50%	40%
True Open Enrollment Y/N	Yes			Yes		
Late Entrant	None			None		
Waiting Period	None			None		
U&C Percentile	Negotiated Fee	MPA	MPA	Negotiated Fee	MPA	MPA
MONTHLY RATES						
Employee	$30.96			$30.96		
Employee & Spouse	$97.12			$97.12		
Employee & Child(ren)	$97.12			$97.12		
Family	$97.12			$97.12		
ESTIMATED ENROLLMENTS						
Employee	102			102		
Employee & Spouse	0			0		
Employee & Child(ren)	0			0		
Family	53			53		
PREMIUM						
Monthly Premium	$8,305.28			$8,305.28		
Annual Premium	$99,663.36			$99,663.36		
Percentage Premium Difference	N/A			0%		
Annual Premium Difference	N/A			$0.00		
Rate Guarantee	1 Year			**2 Years**		
COMMISSION & COMPENSATION						
Commission Level	Flat 7.5%			Flat 7.5%		
Supplemental Compensation	0% to 25% of commission			0% to 25% of commission		

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NORTH BOONE CUSD #200
Vision Rates & Benefits Comparison

EFFECTIVE DATE: JULY 1, 2020

PLAN STATUS:	CURRENT		RENEWAL	
CARRIER(S):	Delta Dental		Delta Dental	
PLAN(S):	Delta Vision Complete		Delta Vision Complete	
NETWORK(S)	Access Network		Access Network	
PLAN BENEFITS	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Minimum Participation				
Examination Copay	$0	Up to $35 Allowance*	$0	Up to $35 Allowance*
Single Vision Lenses	$0	Up to $25 Allowance*	$0	Up to $25 Allowance*
Bifocal Lenses	$0	Up to $40 Allowance*	$0	Up to $40 Allowance*
Trifocal Lenses	$0	Up to $55 Allowance*	$0	Up to $55 Allowance*
Lenticular Lenses	N/A	N/A	N/A	N/A
Frames	$130 Allowance plus 20% off balance	Up to $50 Allowance*	$130 Allowance plus 20% off balance	Up to $50 Allowance*
CONTACT LENSES				
Necessary	100% Covered	Up to $200 Allowance*	100% Covered	Up to $200 Allowance*
Elective	$100 Allowance	Up to $64 Allowance*	$100 Allowance	Up to $64 Allowance*
BENEFITS FREQUENCY				
Exam	12 months		12 months	
Lenses/Contacts	12 months		12 months	
Frames	24 months		24 months	
MONTHLY RATES				
Employee	$7.93		$7.93	
Employee & Spouse	$22.19		$22.19	
Employee & Child(ren)	$22.19		$22.19	
Family	$22.19		$22.19	
ESTIMATED ENROLLMENTS				
Employee	99		99	
Employee & Spouse	0		0	
Employee & Child(ren)	0		0	
Family	39		39	
PREMIUM				
Monthly Premium	$1,650.48		$1,650.48	
Annual Premium	$19,805.76		$19,805.76	
Percentage Premium Difference	N/A		0%	
Annual Premium Difference	N/A		$0.00	
Rate Guarantee	1 Year		**2 Years**	
COMMISSION & COMPENSATION				
Commission Level	Flat 10%		Flat 10%	
Supplemental Compensation	0% to 25% of commission		0% to 25% of commission	

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*** Maximum Dollar Amount paid towards service after material copay.**

Optional carrier rates are subject to final underwriting.

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NORTH BOONE CUSD #200

AJG Disclosures

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COVERAGE NOTICE: This analysis is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

RFP Disclaimer: Much effort has been made to provide all necessary and accurate information. It is the sole responsibility of the proposers to ensure that they have all information necessary to complete submission of their proposals. If more information is needed, please contact Arthur J. Gallagher & Co., 708-223-3300.

Medical, Dental, Vision, EAP & Stop Loss Only

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