North Boone CUSD #200
Medical | Fully-Insured Renewal | Effective 07/01/2025

	CURRENT			RENEWAL			NEGOTIATED RENEWAL		
Carrier Name	BlueCross and BlueShield of Illinois			BlueCross and BlueShield of Illinois			BlueCross and BlueShield of Illinois		
Plan Name	**MIBAV2152**	**MIBPP2160**	**MIEEE4044**	**MIBAV2152**	**MIBPP2160**	**MIEEE4044**	**MIBAV2152**	**MIBPP2160**	**MIEEE4045**
Plan Creditability Status									
PLAN DESIGN*									
In-Network Benefits	Blue Advantage HMO Value Choice	BluePrint PPO	BlueEdge HSA	Blue Advantage HMO Value Choice	BluePrint PPO	BlueEdge HSA	Blue Advantage HMO Value Choice	BluePrint PPO	BlueEdge HSA
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)	$3,000 / $9,000	$4,000 / $12,000	$3,200 / $6,400	$3,000 / $9,000	$4,000 / $12,000	$3,200 / $6,400	$3,000 / $9,000	$4,000 / $12,000	**$3,500 / $7,000**
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$8,700 / $17,400	$5,500 / $12,000	$3,200 / $6,400	$8,700 / $17,400	$5,500 / $12,000	$3,200 / $6,400	$8,700 / $17,400	$5,500 / $12,000	**$3,500 / $7,000**
Coinsurance (member pays after deductible)	20%	20%	0%	20%	20%	0%	20%	20%	0%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	$20 Copay	$30 Copay	0% after deductible	$20 Copay	$30 Copay	0% after deductible	$20 Copay	$30 Copay	0% after deductible
Specialist Visit	$40 Copay	$50 Copay	0% after deductible	$40 Copay	$50 Copay	0% after deductible	$40 Copay	$50 Copay	0% after deductible
Urgent Care	PCP: $20 Copay; SPC: $40 Copay	20% after deductible	0% after deductible	PCP: $20 Copay; SPC: $40 Copay	20% after deductible	0% after deductible	PCP: $20 Copay; SPC: $40 Copay	20% after deductible	0% after deductible
Emergency Room	$400 POD then 20% after deductible (POD waived if admitted)	$150 Copay (Copay waived if admitted)	0% after deductible	$400 POD then 20% after deductible (POD waived if admitted)	$150 Copay (Copay waived if admitted)	0% after deductible	$400 POD then 20% after deductible (POD waived if admitted)	$150 Copay (Copay waived if admitted)	0% after deductible
Inpatient Hospital	$200 Copay then 20% after deductible	20% after deductible	0% after deductible	$200 Copay then 20% after deductible	20% after deductible	0% after deductible	$200 Copay then 20% after deductible	20% after deductible	0% after deductible
Outpatient Surgery	$150 Copay then 20% after deductible	20% after deductible	0% after deductible	$150 Copay then 20% after deductible	20% after deductible	0% after deductible	$150 Copay then 20% after deductible	20% after deductible	0% after deductible
Chiropractic (visit limits may apply)	Covered 100%	20% after deductible (30 visits)	0% after deductible (30 visits)	Covered 100%	20% after deductible (30 visits)	0% after deductible (30 visits)	Covered 100%	20% after deductible (30 visits)	0% after deductible (30 visits)
Phys/Occ/Speech Therapy (visit limits may apply)	20% after deductible; Outpatient: $20 Copay (Combined 60 visits)	20% after deductible (PT/OT/ST: No limit)	0% after deductible (PT/OT/ST: No limit)	20% after deductible; Outpatient: $20 Copay (Combined 60 visits)	20% after deductible (PT/OT/ST: No limit)	0% after deductible (PT/OT/ST: No limit)	20% after deductible; Outpatient: $20 Copay (Combined 60 visits)	20% after deductible (PT/OT/ST: No limit)	0% after deductible (PT/OT/ST: No limit)
Diagnostic Test (X-ray, blood work)	Covered 100%	PCP:$30 Copay; SPC: $50 Copay	0% after deductible	Covered 100%	PCP:$30 Copay; SPC: $50 Copay	0% after deductible	Covered 100%	PCP:$30 Copay; SPC: $50 Copay	0% after deductible
Imaging (CT/PET scan, MRI)	Covered 100%	20% after deductible	0% after deductible	Covered 100%	20% after deductible	0% after deductible	Covered 100%	20% after deductible	0% after deductible
Prescription Drug Benefit									
Retail	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days
Tier I / Tier II / Tier III / Tier IV	$0 / $10 / $50 / $100	Preferred: $0 / $10 / $35 / $75; Non-Preferred: $10 / $20 / $55 / $95	0% after deductible	$0 / $10 / $50 / $100	Preferred: $0 / $10 / $35 / $75; Non-Preferred: $10 / $20 / $55 / $95	0% after deductible	$0 / $10 / $50 / $100	Preferred: $0 / $10 / $35 / $75; Non-Preferred: $10 / $20 / $55 / $95	0% after deductible
Specialty	Preferred: $150; Non-Preferred: $250	Preferred: $150; Non-Preferred: $250	0% after deductible	Preferred: $150; Non-Preferred: $250	Preferred: $150; Non-Preferred: $250	0% after deductible	Preferred: $150; Non-Preferred: $250	Preferred: $150; Non-Preferred: $250	0% after deductible
Mail Order	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV	$0 / $30 / $150 / $300	$0 / $30 / $105 / $225	0% after deductible	$0 / $30 / $150 / $300	$0 / $30 / $105 / $225	0% after deductible	$0 / $30 / $150 / $300	$0 / $30 / $105 / $225	0% after deductible
Out-of-Network Benefits									
Deductible Type	N/A	Embedded	Embedded	N/A	Embedded	Embedded	N/A	Embedded	Embedded
CY Deductible (Individual / Family)	N/A	$8,000 / $24,000	$6,400 / $12,800	N/A	$8,000 / $24,000	$6,400 / $12,800	N/A	$8,000 / $24,000	**$7,000 / $14,000**
Out-of-Pocket Max Type	N/A	Embedded	Embedded	N/A	Embedded	Embedded	N/A	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	N/A	$16,500 / $36,000	$6,400 / $12,800	N/A	$16,500 / $36,000	$6,400 / $12,800	N/A	$16,500 / $36,000	**$7,000 / $14,000**
Coinsurance (member pays after deductible)	N/A	40%	0%	N/A	40%	0%	N/A	40%	0%
COST ANALYSIS									
PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	MIBAV2152	MIBPP2160	MIEEE4044	MIBAV2152	MIBPP2160	MIEEE4044	MIBAV2152	MIBPP2160	MIEEE4045
Employee (EE) Only	1	118	16	$779.94	$799.67	$806.11	$884.45	$906.83	$914.13	$832.37	$853.42	$860.30
EE + Spouse	0	10	2	$1,667.52	$1,709.70	$1,723.45	$1,890.97	$1,938.80	$1,954.39	$1,779.61	$1,824.63	$1,839.30
EE + Child(ren)	0	16	1	$1,521.67	$1,560.16	$1,572.70	$1,725.57	$1,769.22	$1,783.44	$1,623.96	$1,665.03	$1,678.42
EE + Family	0	14	2	$2,410.02	$2,470.98	$2,490.86	$2,732.96	$2,802.09	$2,824.64	$2,572.02	$2,637.08	$2,658.30
Total Enrollment	**1**	**158**	**21**									
Estimated Monthly Premium				$780	$171,014	$22,899	$884	$193,931	$25,968	$832	$182,509	$24,438
Estimated Annual Premium				**$9,359**	**$2,052,172**	**$274,789**	**$10,613**	**$2,327,169**	**$311,611**	**$9,988**	**$2,190,114**	**$293,261**
Dollar Difference from Current							**$1,254**	**$274,997**	**$36,822**	**$629**	**$137,941**	**$18,472**
Percent Change from Current							**13.4%**	**13.4%**	**13.4%**	**6.7%**	**6.7%**	**6.7%**
Total Combined Annual Cost												
				CURRENT			**RENEWAL**			**NEGOTIATED RENEWAL**		
Estimated Annual Premium				**$2,336,320**			**$2,649,393**			**$2,493,363**		
Dollar Difference from Current							**$313,073**			**$157,043**		
Percent Change from Current							**13.4%**			**6.7%**		
PLAN PROVISIONS												
Rate Guarantee				1 Year rate guarantee ending 06/30/2025			1 Year rate guarantee ending 06/30/2026			1 Year rate guarantee ending 06/30/2026		
Eligibility				FTE 32HRS/WK			FTE 32HRS/WK			FTE 32HRS/WK		

**NOTE: Benefit deviations from Current are identified in blue font*