

Illinois Heartland Library System Group Medical Plan Analysis Renewal Effective: July 1, 2015		Coventry Dual Current Plan									Negotiated Coventry Renewal - Rec'd. May 26th						
		PPO AR 5000-14 RX: PSV5-5000 Base Plan PPO Network Higher Deductible			PPO AR 3000-14 RX: PSV5-5000 Buy-Up Plan PPO Network Lower Deductible			PPO AR 5000-14 RX: PSV5-5000 Base Plan PPO Network Higher Deductible			PPO AR 3000-14 RX: PSV5-5000 Buy-Up Plan PPO Network Lower Deductible						
		Premium	Employer Cost	Employee Cost	Premium	Employer Cost	Employee Cost	Premium	Employer Cost	Employee Cost	Premium	Employer Cost	Employee Cost				
		Rates	Counts														
Employee Only	45	38	\$775.79	\$775.79	\$0.00	7	\$848.03	\$775.79	\$72.24	38	\$861.88	\$861.88	\$0.00	7	\$934.92	\$861.88	\$73.04
Employee and Spouse	1	1	\$1,518.24	\$775.79	\$742.45	0	\$1,659.63	\$775.79	\$883.84	1	\$1,686.71	\$861.88	\$824.83	0	\$1,829.69	\$861.88	\$967.81
Employee and Child(ren)	2	1	\$1,433.61	\$775.79	\$657.82	1	\$1,567.12	\$775.79	\$791.33	1	\$1,592.69	\$861.88	\$730.81	1	\$1,727.70	\$861.88	\$865.82
Family		0	\$2,478.69	\$775.79	\$1,702.90	0	\$2,709.46	\$775.79	\$1,933.67	0	\$2,753.73	\$861.88	\$1,891.85	0	\$2,987.10	\$861.88	\$2,125.22
Estimated Monthly Premium (Broken Out)		40	\$32,431.87	\$31,031.60	\$1,400.27	8	\$7,503.33	\$6,206.32	\$1,297.01	40	\$36,030.84	\$34,475.20	\$1,555.64	8	\$8,272.14	\$6,895.04	\$1,377.10
Estimated Monthly Employer Cost (Base & Buy-Up)							\$37,237.92								\$41,370.24		
Estimated Annual Employer Cost (Base & Buy-Up)							\$446,855.04								\$496,442.88		
Estimated Monthly Employee Cost (Base & Buy-Up)							\$2,697.28								\$2,932.74		
Estimated Annual Employee Cost (Base & Buy-Up)							\$32,367.36								\$35,192.88		
Estimated Monthly Premium Combined Base & Buy-Up							\$39,935.20								\$44,302.98		
Estimated Annual Premium Combined Base & Buy-Up							\$479,222.40								\$531,635.76		
Annual Dollar Change From Current							<i>NOT APPLICABLE</i>								\$52,413.36		
Annual Percentage Change From Current							<i>NOT APPLICABLE</i>								10.94%		
Benefits			In-Network	OOB			In-Network	OOB			In-Network	OOB			In-Network	OOB	
Deductible																	
Individual			\$5,000	\$7,000			\$3,000	\$6,000			\$5,000	\$7,000			\$3,000	\$6,000	
Family			\$10,000	\$14,000			\$6,000	\$12,000			\$10,000	\$14,000			\$6,000	\$12,000	
Coinsurance %			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible	
Out-of-Pocket Maximum			Includes Deductible				Includes Deductible				Includes Deductible				Includes Deductible		
Individual			\$6,000*	\$12,000*			\$5,000*	\$8,000*			\$6,000*	\$12,000*			\$5,000*	\$8,000*	
Family			\$12,000*	\$24,000*			\$10,000*	\$16,000*			\$12,000*	\$24,000*			\$10,000*	\$16,000*	
Lifetime Maximum			Unlimited Combined				Unlimited Combined				Unlimited Combined				Unlimited Combined		
Hospital Services																	
Inpatient Hospital			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible	
Outpatient Hospital/Surgery			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible	
Emergency Room / Urgent Care Copay			\$200 / \$50	\$200 / \$50			\$200 / \$50	\$200 / \$50			\$200 / \$50	\$200 / \$50			\$200 / \$50	\$200 / \$50	
Lab			\$0	60% After Deductible			\$0	60% After Deductible			\$0	60% After Deductible			\$0	60% After Deductible	
Diagnostic and X-Ray			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible			100% After Deductible	60% After Deductible	
Office Visit																	
Primary Care			\$25 Copay	60% After Deductible			\$25 Copay	60% After Deductible			\$25 Copay	60% After Deductible			\$25 Copay	60% After Deductible	
Specialist			\$50 Copay	60% After Deductible			\$50 Copay	60% After Deductible			\$50 Copay	60% After Deductible			\$50 Copay	60% After Deductible	
Preventive Care			\$0 Copay	60% After Deductible			\$0 Copay	60% After Deductible			\$0 Copay	60% After Deductible			\$0 Copay	60% After Deductible	
Prescription Drugs (In Network Only)																	
			Retail	Mail Order			Retail	Mail Order			Retail	Mail Order			Retail	Mail Order	
Tier 1			\$15 Copay	\$30 Copay			\$15 Copay	\$30 Copay			\$15 Copay	\$30 Copay			\$15 Copay	\$30 Copay	
Tier 2			\$40 Copay	\$80 Copay			\$40 Copay	\$80 Copay			\$40 Copay	\$80 Copay			\$40 Copay	\$80 Copay	
Tier 3			\$65 Copay	\$130 Copay			\$65 Copay	\$130 Copay			\$65 Copay	\$130 Copay			\$65 Copay	\$130 Copay	
Specialty				Not Covered				Not Covered				Not Covered				Not Covered	

The above Benefit Summary is for "Illustrative Purposes" only. Final Rates are based on actual enrollment. This is a brief outline and does not reflect the Plan's exclusions, limitations and/or restrictions. This is not considered a contract or guarantee of coverage under the plan. In the event of any difference between this summary and the Certificate Booklet, the Certificate Booklet will prevail.