Health Insurance Cost and Coverage Comparisons

FY19 and FY20 Cost Comparisons

	FY19			FY20				
	Annual Premiums	annual employee contribution	annual district contribution	Annual Premiums	annual employee contribution	annual district contribution	$ Diff	% Diff
SINGLE								
BC3T10-RX10/20/45	11,546.40	1,713.84	9,832.56	12,481.66	2,059.18	10,422.48	589.92	6.0%
ABSOS20/401KDED-RX10/20/45	8,189.64	-	8,189.64	8,853.00	-	8,853.00	663.36	8.1%
AB10IPDED-RX10/20/45	10,528.80	696.24	9,832.56	11,381.63	959.15	10,422.48	589.92	6.0%
2 PERSON								
BC3T10-RX10/20/45	23,092.68	5,324.16	17,768.52	24,963.19	6,128.47	18,834.72	1,066.20	6.0%
ABSOS20/401KDED-RX10/20/45	16,379.40	-	16,379.40	17,706.13	-	17,706.13	1,326.73	8.1%
AB10IPDED-RX10/20/45	21,057.60	3,289.08	17,768.52	22,763.27	3,928.55	18,834.72	1,066.20	6.0%
FAMILY								
BC3T10-RX10/20/45	31,175.16	9,063.84	22,111.32	33,700.35	10,262.31	23,438.04	1,326.72	6.0%
ABSOS20/401KDED-RX10/20/45	22,112.16	-	22,112.16	23,903.24	465.20	23,438.04	1,325.88	6.0%
AB10IPDED-RX10/20/45	28,427.88	6,316.56	22,111.32	30,730.54	7,292.50	23,438.04	1,326.72	6.0%

Percent Increase Over Previous Year -1% 8.1%

Please note that all newly hired teachers can ONLY take the ABSOS Plan

Health Plan Comparisons

Health Plan	AB10IPDED	ABSOS	BC3T10
Prescription	Rx 10/20/45	Rx 10/20/45	Rx 10/20/45
	Plan Coverage		
Office Visit Copay	$10	OV $20/SV $40	$10 with referral; $30 for direct care
ER Copay	$75	$100	$50
Urgent Care Copay	$75	$50	$50
Option 2 Deductible*	n/a	n/a	n/a; covered 80%
Option 3 Deductible**	n/a	n/a	$150/$450; covered 80% after deductible
Standard Deductible	$250/$750	$1000/$3000	n/a
Chiro Visit Max	12 visits	Unlimited (if medical necessity)	Unlimited with referral
PT, OT, ST Max	visits combin	0 visits combine	Unlimited with referral
Durable Medical Equipment	Covered 80%, after $100 deductible	Covered 80%, after $100 deductible	Covered 100% with referral
	Prescription Coverage		
Short Term Rx Copay (up to 34-day supply)	$10 Generic $20 Preferred $45 Non-pref	$10 Generic $20 Preferred $45 Non-prefer	$10 Generic $20 Preferred $45 Non-preferred
Long Term Rx Copay (up to 90-day supply)	$10 Generic $20 Preferred $45 Non-pref	$10 Generic $20 Preferred $45 Non-prefer	$10 Generic $20 Preferred $45 Non-preferred

OV - Office Visit Copayment/ SV - Speciality Office Visit

* Deductible on certain in-network services without PCP

** Deductible on services accessed outside of the network