NIS National Insurance Services

Clintondale Community Schools

HEALTH BENEFIT/COST ANALYSIS

Admin and AFSCME

	Current Plan Admin and AFSCME	Renewal Plan Admin and AFSCME	Current Plan Admin and AFSCME	Renewal Plan Admin and AFSCME	Current Plan Admin and AFSCME	Renewal Plan Admin and AFSCME	MESSA Admin and AFSCME	MESSA Admin and AFSCME	MESSA Admin and AFSCME
Plan Name	Priority Health HRA $250	Priority Health HRA $250	Priority Health HRA $500	Priority Health HRA $500	Priority Health HRA $1,000	Priority Health HRA $1,000	ABC Plan 1 (7U) ABC Rx	ABC Plan 1 (DF) 20% 3-tier Rx	Essentials
Provider Network	Priority Health POS	Priority Health POS	Priority Health POS	Priority Health POS	Priority Health POS	Priority Health POS	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Policy or Calendar Year Deductible	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar
Single	$250	$250	$500	$500	$1,000	$1,000	$1,400	$1,400	$375
Family	$500	$500	$1,000	$1,000	$2,000	$2,000	$2,800	$2,800	$750
Coinsurance	0% to first $6,000/$12,000 including deductible	0% to first $6,000/$12,000 including deductible	0% to first $6,000/$12,000 including deductible	0% to first $6,000/$12,000 including deductible	0% to first $6,000/$12,000 including deductible	0% to first $6,000/$12,000 including deductible	0%	20%	20%
Single Coinsurance / OOP Max	$1,900 excluding Rx co-pays	$1,900 excluding Rx co-pays	$1,900 excluding Rx co-pays	$1,900 excluding Rx co-pays	$1,900 excluding Rx co-pays	$1,900 excluding Rx co-pays	$2,400	$4,400	$8,700
Family Coinsurance / OOP Max	$3,800 excluding Rx copays	$3,800 excluding Rx copays	$3,800 excluding Rx copays	$3,800 excluding Rx copays	$3,800 excluding Rx copays	$3,800 excluding Rx copays	$4,800	$7,050	$17,400
Office and Virtual Visits	$0 Virtual/$20 In-person	$0 Virtual/$20 In-person	$0 Virtual/$20 In-person	$0 Virtual/$20 In-person	$0 Virtual/$20 In-person	$0 Virtual/$20 In-person	no cost after deductible	20% after deductible	$10/$25
Specialty Visits	$35.00	$35.00	$35.00	$35.00	$35.00	$35.00	no cost after deductible	20% after deductible	$50.00
Urgent Care	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00	no cost after deductible	20% after deductible	$50.00
Emergency Room	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00	no cost after deductible	20% after deductible	$200.00
Chiropractic Visits	Up to 30 visits	Up to 30 visits	Up to 30 visits	Up to 30 visits	Up to 30 visits	Up to 30 visits	Up to 38 visits	Up to 38 visits	Up to 12 visits, $25 copay
Physical Therapy, Occ Therapy, Speech Therapy	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to 60 combined visits PT/OT; Separate 60 visits for Covered	Up to combined 60 visits	Up to combined 60 visits	Up to combined 30 visits
Bariatric Surgery	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	No specified in proposal
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	No specified in proposal
Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Covered
Retail Prescription Drugs	$15/$50/$80/$50/$80	$15/$50/$80/$50/$80	$15/$50/$80/$50/$80	$15/$50/$80/$50/$80	$15/$50/$80/$50/$80	$15/$50/$80/$50/$80	$0/$2/$10 Generic Copays $0/$20/$40 Pref & Non-pref Brand	$0/$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref
Mail Order Rx	1x copay for tiers 1/2/3	1x copay for tiers 1/2/3	1x copay for tiers 1/2/3	1x copay for tiers 1/2/3	1x copay for tiers 1/2/3	1x copay for tiers 1/2/3	2x copay	2.5x copay	3x copay
	Current 2021 Rates and Caps	Renewal 2022 Rates and Caps	Current 2021 Rates and Caps	Renewal 2022 Rates and Caps	Current 2021 Rates and Caps	Renewal 2022 Rates and Caps	Proposed	Proposed	Proposed
Single	$658.52	$708.31	$643.90	$693.69	$633.81	$683.60	$743.31	$644.29	$564.57
Double	$1,566.45	$1,685.07	$1,531.37	$1,649.99	$1,507.18	$1,625.80	$1,672.45	$1,449.65	$1,270.30
Family	$1,771.99	$1,904.71	$1,728.14	$1,860.86	$1,697.90	$1,830.62	$2,081.26	$1,803.99	$1,580.79
Monthly Cost to PA 152 Hard Cap									
Single	$71.53	$99.60	$56.91	$84.98	$46.82	$74.89	$134.60	$35.58	($44.14)
Double	$338.87	$412.07	$303.79	$376.99	$279.60	$352.79	$399.45	$176.65	($2.70)
Family	$171.10	$244.59	$127.25	$200.74	$97.01	$170.50	$421.14	$143.87	($79.33)

This comparison is intended to illustrate the carrier's proposed services and rates and should not be relied upon to fully determine benefits and rates. Refer to carrier's renewal/proposal for a complete representation of coverage terms and conditions.

McLaren and HAP declined to quote as uncompetitive

NIS National Insurance Services

Clintondale Community Schools

HEALTH BENEFIT/COST ANALYSIS

Teachers and Librarians

	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	Priority Health Whole Group	Priority Health Whole Group	Priority Health Whole Group
Plan Name	ABC Plan 1 HSA 0% ABC Rx	ABC Plan 1 HSA 0% ABC Rx	ABC Plan 1 HSA 20% 3-tier Rx	ABC Plan 1 HSA 20% 3-tier Rx	Essentials	Essentials	POS TRAD $400 80%	POS HSA $1400 0%	POS HSA $1400 20%
Provider Network	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Priority Health	Priority Health	Priority Health
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible method	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar
Single	$1,400	$1,400	$1,400	$1,400	$375	$375	$400	$1,400	$1,400
Family	$2,800	$2,800	$2,800	$2,800	$750	$750	$800	$2,800	$2,800
Coinsurance	0%	0%	20%	20%	20%	20%	20%	0%	20%
Single Coinsurance / OOP Max	$2,400	$2,400	$4,400	$4,400	$8,700	$8,700	$800 Coins/$8,550 OOP	$2,800	$2,800
Family Coinsurance / OOP Max	$4,800	$4,800	$7,050	$7,050	$17,400	$17,400	$1,600 Coins/$17,100 OOP	$5,600	$5,600
Office and Virtual Visits	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$10/$25	$10/$25	$25.00	no cost after deductible	20% after deductible
Specialty Visits	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$50.00	$50.00	$40.00	no cost after deductible	20% after deductible
Urgent Care	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$50.00	$50.00	$55.00	no cost after deductible	20% after deductible
Emergency Room	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$200.00	$200.00	$250.00	no cost after deductible	20% after deductible
Chiropractic Visits	Up to 38 visits	Up to 38 visits	Up to 38 visits	Up to 38 visits	Up to 12 visits, $25 copay	Up to 12 visits, $25 copay	Up to 30 visits, $25 copay	Up to 30 visits	20% coinsurance, max 30 visits
Physical Therapy, Occ Therapy, Speech Therapy	Up to combined 60 visits	Up to combined 60 visits	Up to combined 60 visits	Up to combined 60 visits	Up to combined 30 visits	Up to combined 30 visits	Up to 30 visits, $25 copay	Up to 30 visits	20% coinsurance, max 30 visits
Bariatric Surgery	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Covered	Covered	Covered
Acupuncture	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not specified	Not specified	Not specified
Hearing Aids	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Not Covered	Not Covered	One hearing test plus one hearing aid every 36 contract months; in network only.	One hearing test plus one hearing aid every 36 contract months; in network only.	One hearing test plus one hearing aid every 36 contract months; in network only.
Retail Prescription Drugs	$0/$2/$10 Generic Copays $0/$20/$40 Pref & Non-pref Brand	$0/$2/$10 Generic Copays $0/$20/$40 Pref & Non-pref Brand	$0/$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$0/$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10/$40/$80/$40/$80, deductible N/A	$10/$40/$80/$40/$80 after deductible	$10/$40/$80/$40/$80 after deductible
Mail Order Rx	2x copay	2x copay	2.5x copay	2.5x copay	3x copay	3x copay	2x copay	2x copay	2x copay
	Current	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**	**Proposed Whole Group**	**Proposed Whole Group**	**Proposed Whole Group**
Single 1	$692.79	$728.44	$600.50	$631.41	$520.95	$553.28	$595.11	$509.34	$452.25
Double 1	$1,558.80	$1,639.01	$1,351.14	$1,420.66	$1,172.14	$1,244.89	$1,339.00	$1,146.02	$1,017.56
Family 1	$1,939.81	$2,039.64	$1,681.39	$1,767.92	$1,458.64	$1,549.18	$1,666.30	$1,426.15	$1,266.30
Monthly Cost to PA 152 Hard Cap									
Single	$105.80	$119.73	$13.51	$22.70	($66.04)	($55.43)	($13.60)	($99.37)	($156.46)
Double	$331.22	$366.01	$123.56	$147.66	($55.44)	($28.11)	$66.00	($126.98)	($255.44)
Family	$338.92	$379.52	$80.50	$107.80	($142.25)	($110.94)	$6.18	($233.97)	($393.82)

This comparison is intended to illustrate the carrier's proposed services and rates and should not be relied upon to fully determine

McLaren Declined to quote
HAP Declined to quote

NIS National Insurance Services

Clintondale Community Schools

HEALTH BENEFIT/COST ANALYSIS

Teachers and Librarians

	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	MESSA Teachers & Librarian	Blue Cross PPO Teachers & Librarian	Blue Cross PPO Teachers & Librarian
Plan Name	ABC Plan 1 HSA 0% ABC Rx	ABC Plan 1 HSA 0% ABC Rx	ABC Plan 1 HSA 20% 3-tier Rx	ABC Plan 1 HSA 20% 3-tier Rx	Essentials	Essentials	1400 HSA 0%	1400 HSA 20%
Provider Network	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Blue Cross PPO	Simply Blue	Simply Blue
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible method	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar
Single	$1,400	$1,400	$1,400	$1,400	$375	$375	$1,400	$1,400
Family	$2,800	$2,800	$2,800	$2,800	$750	$750	$2,800	$2,800
Coinsurance	0%	0%	20%	20%	20%	20%	0%	20%
Single Coinsurance / OOP Max	$2,400	$2,400	$4,400	$4,400	$8,700	$8,700	$4,000	$4,000
Family Coinsurance / OOP Max	$4,800	$4,800	$7,050	$7,050	$17,400	$17,400	$8,000	**$8,000**
Office and Virtual Visits	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$10/$25	$10/$25	no cost after deductible	20% after deductible
Specialty Visits	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$50.00	$50.00	no cost after deductible	20% after deductible
Urgent Care	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$50.00	$50.00	no cost after deductible	20% after deductible
Emergency Room	no cost after deductible	no cost after deductible	20% after deductible	20% after deductible	$200.00	$200.00	no cost after deductible	20% after deductible
Chiropractic Visits	Up to 38 visits	Up to 38 visits	Up to 38 visits	Up to 38 visits	Up to 12 visits, $25 copay	Up to 12 visits, $25 copay	Covered	Covered
Physical Therapy, Occ Therapy, Speech Therapy	Up to combined 60 visits	Up to combined 60 visits	Up to combined 60 visits	Up to combined 60 visits	Up to combined 30 visits	Up to combined 30 visits	Up to combined 30 visits	Up to combined 30 visits
Bariatric Surgery	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Covered	Covered
Acupuncture	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Covered up to maximum benefit, adjusted annually	Not Covered	Not Covered	Not Covered	Not Covered
Retail Prescription Drugs	$0/$2/$10 Generic Copays $0/$20/$40 Pref & Non-pref Brand	$0/$2/$10 Generic Copays $0/$20/$40 Pref & Non-pref Brand	$0/$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$0/$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10 Generic Copays 20% ($40 min - $80 max) Pref Brand 20% ($60 min - $100 max) Non-pref	$10/$0/$80	$10/$0/$80
Mail Order Rx	2x copay	2x copay	2.5x copay	2.5x copay	3x copay	3x copay	2x copay	2x copay
	Current	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**	**Proposed**	**Proposed**
Single	$692.79	$728.44	$600.50	$631.41	$520.95	$553.28	$598.18	$516.80
Double	$1,558.80	$1,639.01	$1,351.14	$1,420.66	$1,172.14	$1,244.89	$1,435.63	$1,240.32
Family	$1,939.81	$2,039.64	$1,681.39	$1,767.92	$1,458.64	$1,549.18	$1,794.54	$1,550.40
Monthly Cost to PA 152 Hard Cap								
Single	$105.80	$119.73	$13.51	$22.70	($66.04)	($55.43)	($10.53)	($91.91)
Double	$331.22	$366.01	$123.56	$147.66	($55.44)	($28.11)	$162.63	($32.68)
Family	$338.92	$379.52	$80.50	$107.80	($142.25)	($110.94)	$134.42	($109.72)

This comparison is intended to illustrate the carrier's proposed services and rates and should not be relied upon to fully determine

McLaren Declined to quote
HAP Declined to quote

Clintondale Community Schools

HEALTH BENEFIT/COST ANALYSIS

Whole Group Plans

		Blue Cross PPO Whole Group	Blue Cross PPO Whole Group	Blue Cross PPO Whole Group
Plan Name		SB Plan 500 LG	SB HSA 1400 HSA 0%	SB HSA 1400 HSA 20%
Provider Network		Simply Blue	Simply Blue	Simply Blue
		In-Network	In-Network	In-Network
Policy or Calendar Year		Calendar	Calendar	Calendar
Deductible				
Single		$500	$1,400	$1,400
Family		$1,000	$2,800	$2,800
Coinsurance		0%	0%	20%
Single Coinsurance / OOP Max		$2,500	$4,000	$4,000
Family Coinsurance / OOP Max		$8,150	$8,000	$8,000
Office and Virtual Visits		no cost after deductible	no cost after deductible	20% after deductible
Specialty Visits		no cost after deductible	no cost after deductible	20% after deductible
Urgent Care		no cost after deductible	no cost after deductible	20% after deductible
Emergency Room		no cost after deductible	no cost after deductible	20% after deductible
Chiropractic Visits				
Physical Therapy, Occ Therapy, Speech Therapy				
Bariatric Surgery				
Acupuncture				
Hearing Aids				
Retail Prescription Drugs		$10/$40/$80	$10/$40/$80	$10/$0/$80
Mail Order Rx				
		Proposed	**Proposed**	**Proposed**
Single	1	$739.07	$698.55	$608.59
Double	1	$1,773.77	$1,676.52	$1,460.63
Family	1	$2,217.22	$2,095.65	$1,825.78
Monthly Cost to PA 152 Hard Cap				
Single		$130.36	$89.84	($0.12)
Double		$500.77	$403.52	$187.63
Family		$557.10	$435.53	$165.66

This comparison is intended to illustrate the carrier's proposed services and rates and should not be relied upon to fully determine benefits and rates. Refer to carrier's renewal/proposal for a complete representation of coverage terms and conditions.

McLaren and HAP Declined to quote