2018 Medical Plans

	CarePlus *Option 6*		CarePlus *Option 13*		CarePlus *Option 14*		MEC Enhanced	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Network	Cigna	Cigna	Cigna		Cigna		First Health Limited Benefit Network	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		N/A	N/A
Calendar Year	Unlimited		Unlimited		Unlimited		N/A	N/A
Deductibles								
Individual	$3,000	$6,000	$3,000	$6,000	$5,000	$10,000	$0	N/A
Family	$6,000	$12,000	$6,000	$12,000	$10,000	$20,000	$0	N/A
Coinsurance	0%	40%	0%	50%	0%	50%	N/A	N/A
Out-of-Pocket Max Maximum								
Individual	$5,000	$10,000	$3,000	$10,000	$6,350	$12,700	N/A	N/A
Family	$10,000	$20,000	$6,000	$20,000	$12,700	$25,400	N/A	N/A
Hospital Services								
Inpatient Hospital	0% After Deductible	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	No Coverage	No Coverage
Outpatient Hospital	0% After Deductible	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	No Coverage	No Coverage
Emergency Room	$250 Copay	$250 Copay	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	No Coverage	No Coverage
Urgent Care	$50 Copay	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	$50 Copay; Maximum 3 visits per calendar year	No Coverage
Routine Services								
Office Visit	$30 Copay	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	$20 Copay; Maximum 3 visits per calendar year	No Coverage
Specialist Visit	$60 Copay	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	$50 Copay; Maximum 3 visits per calendar year	No Coverage
Preventive Care	Covered In Full	40% After Deductible	Covered In Full	50% After Deductible	Covered In Full	Not Covered	100% of allowed amount; Maximum 1 visit per calendar year	No Coverage
Lab & X-Ray	$30 Copay	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	$50 Copay; Maximum 3 visits per calendar year	No Coverage
Chiropractic	$60 Copay	40% After Deductible	0% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible	No Coverage	No Coverage
Prescription Drugs							*ACA approved preventive list only*	
Tier 1	$15 Copay	N/A	0% After Deductible	N/A	$10 After Deductible	N/A	10% Copay	No Coverage
Tier 2	$30 Copay	N/A	0% After Deductible	N/A	$30 After Deductible	N/A	50% Copay	No Coverage
Tier 3	$60 Copay	N/A	0% After Deductible	N/A	$60 After Deductible	N/A	No Coverage	No Coverage
Mail-Order	2.5x Retail	N/A	0% After Deductible	N/A	2.5x Retail After Deductible	N/A	10% / 50% / N/A	No Coverage

Employee Rate Worksheet

Use this worksheet to provide a general estimate of your benefits costs for the upcoming plan year. This is a great place to start planning for you and your family's health and wellness for next year.

MONTHLY INSURANCE RATES FOR 2018 PLAN YEAR

	MEDICAL PLAN #6	MEDICAL PLAN #13	MEDICAL PLAN #14	MEC ENHANCED	DENTAL	VISION
EMPLOYEE ONLY	$386.01	$342.44	$279.61	$129.00	$44.65	$9.40
EMPLOYEE & SPOUSE	$810.66	$719.10	$587.16	$194.00	$88.53	$20.24
EMPLOYEE & CHILDREN	$733.43	$650.61	$531.25	$222.00	$93.78	$16.36
EMPLOYEE & FAMILY	$1,235.27	$1,095.77	$894.74	$277.00	$146.75	$27.20

COST CALCULATOR

Medical Plan Rate	
Dental Plan Rate	
Vision Plan Rate	
TOTAL MONTHLY COST	
	x12 MONTHS
TOTAL ANNUAL COST	
Divide by # of paychecks	÷24 PAYCHECKS
COST PER PAYCHECK	

INSTRUCTIONS

1. Write down the rates for each plan you have chosen.
2. Add up the rates for a Total Monthly Cost.
3. Multiply the Total Monthly Cost by 12 for Annual Cost.
4. Divide the Total Annual Cost by 24 (This is the number of designated paychecks benefit deductions will be taken during the school year.)
5. You now have the approximate Cost per Pay Check for the 2018 School Year.