BCBS Monthly Premium

Pre Employee total $778.69

Hospital Pays 80% = $622.95

Employee Pays 20% =$155.74

Benefits

Deductible $2,100.00

Co-Insurance 30%

Out of Pocket $6,300.00

Clinton Hospital Authority

Medical Cost Analysis

INSURICA

Prepared by INSURICA for your July 1, 2026 Anniversary Date

		CURRENT BLUE CROSS					RENEWAL BLUE CROSS				
		G740ADT			P8K1ADT		G740ADT			P8K1ADT	
		In-Network	Out-of-Network		In-Network	Out-of-Network	In-Network	Out-of-Network		In-Network	Out-of-Network
Rates	**Counts**										
Employee	13	$715.53		5	$856.17		$778.69		5	$926.94	
Employee + Spouse	2	$1,431.06		0	$1,716.34		$1,557.38		0	$1,853.88	
Employee & Children	0	$1,431.06		0	$1,716.34		$1,557.38		0	$1,853.88	
Family	0	$2,146.59		1	$2,574.51		$2,336.07		1	$2,780.82	
Estimated Monthly Premium		$19,029.37					$20,653.25				
Estimated Annual Premium		$228,352					$247,839				
Percentage Change		N/A					8.53%				
Dollar Change		N/A					$19,487				
Deductible											
Individual		$2,100	$4,200		$1,000	$2,000	$2,100	$4,200		$1,000	$2,000
Family		$6,300	$12,600		$3,000	$6,000	$6,300	$12,600		$3,000	$6,000
Coinsurance		30%	40%		10%	30%	30%	40%		10%	30%
Out-of-Pocket Maximum											
Individual		$5,250	Unlimited		$2,250	Unlimited	$5,250	Unlimited		$2,250	Unlimited
Family		$15,750	Unlimited		$6,750	Unlimited	$15,750	Unlimited		$6,750	Unlimited
Inpatient		Ded. + $300 + 30%	Ded. + $400 + 40%		Ded. + $150 + 10%	Ded. + $250 + 30%	Ded. + $300 + 30%	Ded. + $400 + 40%		Ded. + $150 + 10%	Ded. + $250 + 30%
Outpatient		Ded. + $300 + 30%	Ded. + $400 + 40%		Ded. + $100 + 10%	Ded. + $200 + 30%	Ded. + $300 + 30%	Ded. + $400 + 40%		Ded. + $100 + 10%	Ded. + $200 + 30%
Emergency Room		Ded. + $750 + 30%			Ded. + $300 + 10%		Ded. + $750 + 30%			Ded. + $300 + 10%	
Urgent Care		$50/visit	30% after ded.		$50/visit	30% after ded.	$50/visit	30% after ded.		$50/visit	30% after ded.
Primary Dr. Visit		$50/visit	30% after ded.		$25/visit	30% after ded.	$50/visit	30% after ded.		$25/visit	30% after ded.
Specialist Dr. Visit		$75/visit	30% after ded.		$45/visit	30% after ded.	$75/visit	30% after ded.		$45/visit	30% after ded.
Preventative Care		No charge	30% after ded.		No charge	30% after ded.	No charge	30% after ded.		No charge	30% after ded.
Prescription Drugs											
Generic		$10/$20/$30	$20/$30		$0/$10/$20	$10/$20	$10/$20/$30	$20/$30		$0/$10/$20	$10/$20
Brand		$50/$70	$70		$35/$55	$55	$50/$70	$70		$35/$55	$55
Non-Preferred Brand		$100/$120	$120		$75/$95	$95	$100/$120	$120		$75/$95	$95
Specialty Drugs		$250/$350	$250/$350 + 50%		$250/$350	$250/$350 + 50%	$250/$350	$250/$350 + 50%		$250/$350	$250/$350 + 50%
Mail Order		3x Copay	Not Covered		3x Copay	Not Covered	3x Copay	Not Covered		3x Copay	Not Covered