Rockford Public Schools

Public Act 106 Bidding Results

Gallagher

Insurance | Risk Management | Consulting

Proposals Requested

Line of Coverage	Carrier	Result
Medical/Rx	BCBSM - MESSA	Current
	BCBSM - Direct	Quoted
	BCBSM – The Pool	Quoted
	PriorityHealth	Bid Pending
Dental	ADN Dental	Current
	BCBSM	Quoted
	Guardian	Quoted
Vision	VSP - MESSA	
	VSP – Blue Cross	Declined, Exclusitivy
	EyeMed	Quoted
	Guardian	Declined, Uncompetitive

Medical Quote Summaries – ABC Plan 1

Vendor Plan Name Plan Type	MESSA ABC Plan 1 HDHP/H.S.A	POOL Flexible Blue 2 HDHP/H.S.A.	BCBS Direct Simply Blue HSA PPO HDHP/H.S.A.
Plan Highlights	In-Network	In-Network	In-Network
Individual Deductible	$1,600	$1,600	$1,600
Family Deductible	$3,200	$3,200	$3,200
Coinsurance (Insurance Pays)	100%	100%	N/A
Individual Out of Pocket Max	$2,600	$2,600	$4,000
Family Out of Pocket Max	$5,200	$5,200	$8,000
Covered Benefits			
Preventative Care	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	100% after deductible	100% after deductible	100% after deductible
Specialist Office Visit	100% after deductible	100% after deductible	90% after deductible
Urgent Care Visit	100% after deductible	100% after deductible	100% after deductible
Emergency Room	100% after deductible	100% after deductible	100% after deductible
Hospital Services	100% after deductible	100% after deductible	100% after deductible
Chiropractic	100% after deductible (36 visits, combined with massage)	100% after deductible (24 visits)	100% after deductible (12 visits)
Massage	100% after deductible (36 visits, combined with chiropractic)	Not Covered	Not Covered
PT/OT/Speech combined	100% after deductible (60 visits)	100% after deductible (60 visits)	100% after deductible (60 visits)
Prescription Drugs			
Generic	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible
Preferred Brand	$40 copay after deductible	$40 copay after deductible	$40 copay after deductible
Non-Preferred Brand	$40 copay after deductible	$40 copay after deductible	$80 copay after deductible
Monthly Premiums			
Employee	$624.75	$624.48	$702.81
EE+ 1	$1,405.70	$1,405.07	$1,686.75
Family	$1,749.30	$1,748.54	$2,108.44
Amount Above/Below Cap			
Single	($17.15)	($17.42)	$60.91
2-Person	$63.28	$62.65	$344.33
Family	($1.35)	($2.11)	$357.79
Total			
Estimated Yearly Change %	--	-0.04%	21.90%

Medical Quote Summaries – ABC Plan 2

Vendor Plan Name Plan Type	MESSA ABC Plan 2 HDHP/H.S.A	POOL Flexible Blue 6 HDHP/H.S.A.	POOL ENHANCED 1000 171 HDHP/H.S.A.	POOL ENHANCED 500 008 Trad PPO
Plan Highlights	In-Network	In-Network		
Individual Deductible	$1,600	$1,600	$1,000	$500
Family Deductible	$3,200	$3,200	$2,000	$1,000
Coinsurance	90%	90%	90%	90%
Individual Coinsurance Max	N/A	$1,000	N/A	$1,000
Family Coinsurance Max	N/A	$2,000	N/A	$2,000
Individual Out of Pocket Max	$4,600	$3,600	$3,000	$3,000
Family Out of Pocket Max	$7,200	$7,200	$6,000	$6,000
Covered Benefits				
Preventative Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	90% after deductible	90% after deductible	$20 copay	$20 copay
Specialist Office Visit	90% after deductible	90% after deductible	$20 copay	$20 copay
Urgent Care Visit	90% after deductible	90% after deductible	$20 copay	$20 copay
Emergency Room	90% after deductible	90% after deductible	$50 copay	$50 copay then 90% after deductible
Hospital Services	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Chiropractic	90% after deductible (36 visits, combined with massage)	90% after deductible (24 visits)	$20 copay (24 visits)	90% after deductible (24 visits)
Massage	90% after deductible (36 visits, combined with chiropractic)	Not Covered	Not Covered	90% after deductible (24 visits)
Prescription Drugs				
Generic	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible	$10 copay
Preferred Brand	20% (min $40, max $80) after deductible	20% (min $40, max $80) after deductible	20% (min $40, max $80) after deductible	$40 copay
Non-Preferred Brand	20% (min $60, max $100) after deductible	20% (min $60, max $100) after deductible	20% (min $60, max $100) after deductible	$40 copay
Monthly Premiums				
Employee	$549.35	$552.81	$578.36	$654.36
EE+ 1	$1,236.06	$1,243.81	$1,301.31	$1,472.30
Family	$1,538.19	$1,547.85	$1,619.41	$1,832.20
Amount Above/Below Cap				
Single	($92.55)	($89.09)	($63.54)	$12.46
2-Person	($106.36)	($98.61)	($41.11)	$129.88
Family	($212.46)	($202.80)	($131.24)	$81.55

Dental Quote Summary

	ADN Dental Network	Guardian Life Insurance Co. - Self-Funded Estimate	Guardian Life Insurance Co. - Fully Insured	Blue Cross Blue Shield of MI - Self-Funded Estimate	Blue Cross Blue Shield of MI - Fully Insured
Total Estimated Cost	$995,325	$895,792	$995,325	$835,152	$858,716
$ Difference From Current		($99,532)	$0	($160,173)	($136,609)
% Difference from Current					

Admin Fee Comparison (Self-Funded Proposals)
ADN - $7.10 PEPM
Guardian - $5.95 PEPM
BCBS - $5.21 PEPM

BCBSM Self-Funded Proposal Summary

	Blue Cross Blue Shield of Michigan - Self Funded Estimate											
Enrollment Tier	**Teachers with Medical**		**Teachers w/o Medical**		**Administration / Central Office**		**Secretaries w/o Medical**		**Non-Union / Childcare**		**Union Support Staff / Security**	
Employee	71		11		4		0		4		45	
2 Person	56		6		16		0		8		69	
Family	263		40		33		5		9		129	
Total	**390**		**57**		**53**		**5**		**21**		**243**	
Plan Provisions	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive - Class I Services	80%	80%	100%	100%	100%	100%	80%	80%	80%	80%	80%	80%
Restorative - Class II Services	80%	80%	90%	90%	100%	100%	80%	80%	80%	80%	80%	80%
Major - Class III Services	80%	80%	90%	90%	80%	80%	80%	80%	80%	80%	80%	80%
Orthodontia- Class IV Services	80%	80%	100%	100%	70%	70%	80%	80%	80%	80%	80%	80%
Out of Network Reimbursement		90% of R&C		90% of R&C		90% of R&C		90% of R&C		90% of R&C		90% of R&C
Maximums												
Annual	$1,500 per member		$1,500 per member		$1,500 per member		$1,500 per member		$1,500 per member		$1,500 per member	
Child Orthodontia	$1,750 up to age 19		$1,000 up to age 19		$2,000 up to age 19		$1,750 up to age 19		$1,750 up to age 19		$1,750 up to age 19	
Plan Costs												
Employee	$32.10		$36.47		$37.24		$32.10		$32.10		$32.10	
2 Person	$64.21		$72.94		$74.48		$64.21		$64.21		$64.21	
Family	$112.36		$127.64		$130.33		$112.36		$112.36		$112.36	
Monthly Total	**$35,426**		**$5,944**		**$5,642**		**$562**		**$1,653**		**$20,369**	
Annual Gross Total	**$425,106**		**$71,333**		**$67,698**		**$6,742**		**$19,840**		**$244,433**	
$ Difference From Current	**($134,133)**		**($2,052)**		**($12,350)**		**($2,590)**		**$1,068**		**($10,115)**	
% Difference From Current	**-24.0%**		**-0.4%**		**-2.2%**		**-0.5%**		**0.2%**		**-1.8%**	

Vision Quote Summary

	Current Vision Plan		Current Vision Plan		Current Vision Plan	
Enrollment Tier	**VSP 3 Plus**		**VSP 2**		**VSP - Vision Preferred**	
Employee	15		7		109	
2 Person	23		8		120	
Family	74		12		384	
Total	**112**		**27**		**613**	
Plan Provisions	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exam	100%	Up to $35	$6.50 Copay	Up to $28.50	100%	Up to $45
Single Vision Lenses	100%		$18 Copay		100%	
Bifocal	100%	Varies based on	$18 Copay	Varies based on	100%	Varies based on Lens
Trifocal	100%	Lens Type	$18 Copay	Lens Type	100%	Type
Lenticular Lenses	100%		$18 Copay		100%	
Frames	$65 Allowance	Up to $55	$65 Allowance	Up to $44	$135 Allowance	Up to $70
Contact Lenses - Medical	100%	Up to $200	100%	Up to $175	100%	Up to $210
Contact Lenses - Elective	$115 Allowance	Up to $115	$90 Allowance	Up to $90	$135 Allowance	Up to $105

	Current Vision Plan	Current Vision Plan	Current Vision Plan
Employee	$8.58	$4.40	$5.57
2 Person	$18.41	$9.42	$11.96
Family	$27.74	$14.20	$18.00

	Option #1		Option #2		Option #3	
Enrollment Tier	**EyeMed - 3 Plus**		**EyeMed - 2**		**EyeMed - Preferred**	
Plan Provisions	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exam	**100%**	**Up to $40**	**$5 Copay**	**Up to $40**	**100%**	**Up to $40**
Single Vision Lenses	**100%**		**$15 Copay**		**100%**	
Bifocal	**100%**	**Varies based on**	**$15 Copay**	**Varies based on**	**100%**	**Varies based on**
Trifocal	**100%**	**Lens Type**	**$15 Copay**	**Lens Type**	**100%**	**Lens Type**
Lenticular Lenses	**100%**		**$15 Copay**		**100%**	
Frames	**$70 Allowance**	**Up to $35**	**$70 Allowance**	**Up to $35**	**$140 Allowance**	**Up to $70**
Contact Lenses - Medical	**100%**	**Up to $300**	**100%**	**Up to $300**	**100%**	**Up to $300**
Contact Lenses - Elective	**$120 Allowance**	**Up to $60**	**$90 Allowance**	**Up to $45**	**$140 Allowance**	**Up to $70**

	Option #1	Option #2	Option #3
Rate Guarantee	**2 Year**	**2 Year**	**2 Year**
Plan Costs	**EyeMed - 3 Plus**	**EyeMed - 2**	**EyeMed - Preferred**
Employee	$6.87	$5.62	$10.41
2 Person	$13.05	$10.68	$19.78
Family	$19.17	$15.68	$29.04
Monthly Total	**$1,822**	**$313**	**$14,660**
Annual Total	**$21,861**	**$3,755**	**$175,916**
PEPY Cost	**$195**	**$139**	**$287**
$ Difference From Current	**($9,397)**	**$437**	**$68,464**
% Difference From Current	**-30.1%**	**13.2%**	**63.7%**

Thank you!

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