# Medical Benefits

## BCBS Healthcare Plan Administrator

Blue Cross Blue Shield continues to be our healthcare provider. As always, you can go to their website **www.bcbsil.com** to learn more.

| | PPO Plan 600A with HRA | | PPO Plan 750 | | PPO Plan 1200 with HRA | | HDHP Plan 1650 with HSA | | HMO 30 Illinois | Blue Advantage HMO 30 |
|---|---|---|---|---|---|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network Only** | **In-Network Only** |
| **DEDUCTIBLE**[1] | | | | | | | | | | |
| Individual | $600 | $1,200 | $750 | $1,500 | $1,200 | $2,400 | $1,650 | | N/A | N/A |
| Family | $1,200 | $2,400 | $1,500 | $3,000 | $2,400 | $4,800 | $3,300 | | N/A | N/A |
| **Coinsurance** | 90% | 70% | 80% | 60% | 80% | 60% | 90% | 70% | 100% | 100% |
| **OUT-OF-POCKET LIMIT**[1] | | | | | | | | | | |
| Individual | $4,400 | $8,000 | $3,800 | $6,800 | $4,250 | $7,700 | $6,350 | | $1,500 | $1,500 |
| Family | $8,800 | $16,000 | $7,600 | $13,600 | $8,500 | $15,400 | $12,700[5] | | $3,000 | $3,000 |
| **Lifetime Maximum** | Unlimited | | Unlimited | | Unlimited | | Unlimited | | Unlimited | Unlimited |
| **Covered Expenses** | | | | | | | | | | |
| **HOSPITAL SERVICES** | | | | | | | | | | |
| Inpatient Services | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Outpatient Services | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Inpatient Admission Copay (Annual 5 visit max copay) | $150 copay, then 90%* | $150 copay, then 70% | $150 copay, then 80%* | $150 copay, then 60% | $150 copay, then 80%* | $150 copay, then 60% | 90%* | 70%* | $150 copay | $150 copay |
| **Emergency Room** | $150 copay and 90%*; inpatient copay applies if admitted | | $150 copay and 90%*; inpatient copay applies if admitted | | $150 copay and 90%*; inpatient copay applies if admitted | | 90%* | 90%* | $150 copay; inpatient copay applies if admitted | $150 copay; inpatient copay applies if admitted |
| **PHYSICIAN** | | | | | | | | | | |
| Inpatient Surgery | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Outpatient Surgery | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Primary Care Office Visits | $30 copay[2] | 70%* | $30 copay[2] | 60%* | $30 copay[2] | 60%* | 90%* (average $44/visit) | 70%* | $30 copay | $30 copay |
| Specialist Office Visit | $50 copay[2] | 70%* | $50 copay[2] | 60%* | $50 copay[2] | 60%* | 90%* | 70%* | $50 copay | $50 copay |
| Preventive Services** | 100% | 70%* | 100% | 60%* | 100% | 60%* | 100% | 70%* | 100% | 100% |
| **OTHER** | | | | | | | | | | |
| Therapy: Speech, Occupational and Physical[1] (annual 60 visit limit for PPO and HDHP) | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | Only if referred through PCP, then copay | Only if referred through PCP, then copay |
| X-ray and Lab | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Chiropractic[1,3] (annual 35-visit limit) | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | Only if referred through PCP, then copay | Only if referred through PCP, then copay |
| Ambulance | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | 100% | 100% |
| Acupuncture[1,4] ($3,000 annual benefit) | 90%* | 70%* | 80%* | 60%* | 80%* | 60%* | 90%* | 70%* | Only if referred through PCP, then copay | Only if referred through PCP, then copay |
| Virtual Visits | $10 copay[2] | N/A | $10 copay[2] | N/A | $10 copay[2] | N/A | 90%* ($44 on average) | N/A | Check with your Medical Group | Check with your Medical Group |
| **PRESCRIPTION DRUGS** | **Prime Therapeutics** | | **Prime Therapeutics** | | **Prime Therapeutics** | | **Prime Therapeutics** | | **Prime Therapeutics** | **Prime Therapeutics** |
| Retail Pharmacy (30-day supply) | $15 Generic; $40 Preferred Brand; $60 Non-Preferred Brand; $100 Specialty | | $15 Generic; $40 Preferred Brand;, $60 Non-Preferred Brand; $100 Specialty | | $15 Generic; $40 Preferred Brand; $60 Non-Preferred Brand; $100 Specialty | | 80% after deductible | | $20 Generic, $40 Preferred Brand, $70 Non-Preferred Brand, | $20 Generic, $40 Preferred Brand, $70 Non-Preferred Brand, |
| Pharmacy or Mail Order (90-day supply) | $30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty | | $30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty | | $30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty | | 80% after deductible | | $40 Generic; $80 Preferred Brand; $140 Non-Preferred Brand | $40 Generic; $80 Preferred Brand; $140 Non-Preferred Brand |
| NEW! Prescription Out-of-Pocket Limit (single / family) | $2,750 / $5,500 | | $2,750 / $5,500 | | $2,750 / $5,500 | | Combined with Medical | | $1,000 / $2,000 | $1,000 / $2,000 |
| **VISION** | **VSP** | | **VSP** | | **VSP** | | **VSP** | | **EyeMed** | **EyeMed** |
| Annual Vision Exam | 100% after $10 copay w/ VSP | Reimbursed up to $45 w/ VSP | 100% after $10 copay w/ VSP | Reimbursed up to $45 w/ VSP | 100% after $10 copay w/ VSP | Reimbursed up to $45 w/ VSP | 100% after $10 copay w/ VSP | Reimbursed up to $45 w/ VSP | 100% w/ EyeMed | 100% w/ EyeMed |
| **HEARING BENEFIT** | One device per ear every 24 months | | One device per ear every 24 months | | One device per ear every 24 months | | One device per ear every 24 months | | One device per ear every 24 months | One device per ear every 24 months |

*Subject to deductible and coinsurance.

**As determined by the USPSTF, see plan booklet for complete details.

1 Deductible, Out-of-Pocket, Chiropractic, Acupuncture, and therapy limits are based on a calendar year.

2 Copays do not apply towards the annual deductible. Copays apply towards the out-of-pocket limit. Copays apply only to office visit charge, not to misc. expense incurred during visit.

3 Chiropractic care that is medically necessary is covered; maintenance care is not covered.

4 See plan booklet or contact BCBS for approved providers.

5. If you are covering dependents and enrolled in the HDHP plan, please note: once a family member meets the individual out-of-pocket limit, coinsurance benefits begin for that individual. No individual will contribute more than the individual out-of-pocket amount to the family out-of-pocket amount.

**Note: The Comparisons are outlines of the benefit schedules. This exhibit in no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operation of the plans.**