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 1500 with HSA		HMO 20 Illinois
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**
DEDUCTIBLE[1]									
Individual	$600	$1,200	$750	$1,500	$1,200	$2,400	$1,500		N/A
Family	$1,200	$2,400	$1,500	$3,000	$2,400	$4,800	$3,000		N/A
Coinsurance	90%	70%	80%	60%	80%	60%	90%	70%	100%
OUT-OF-POCKET LIMIT									
Individual	$4,400	$8,000	$3,800	$6,800	$4,250	$7,700	$6,350		$1,500
Family	$8,800	$16,000	$7,600	$13,600	$8,500	$15,400	$12,700[5]		$3,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited
Covered Expenses									
HOSPITAL SERVICES									
Inpatient Services	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
Outpatient Services	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
NEW 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%	$150 copay, then 80%*	$150 copay, then 60%	$150 copay
Emergency Room	$150 copay & 90%*; inpatient copay applies if admitted		$150 copay & 90%*; inpatient copay applies if admitted		$150 copay & 90%*; inpatient copay applies if admitted		90%*	90%*	$150 copay; Copay Waived If Admitted
PHYSICIAN									
Inpatient Surgery	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
Outpatient Surgery	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
Primary Care Office Visits	$30 copay[2]	70%*	$20 copay[2]	60%*	$20 copay[2]	60%*	$44/visit, 90%*	70%*	$20 copay
Specialist Office Visit	$50 copay[2]	70%*	$40 copay[2]	60%*	$40 copay[2]	60%*	90%*	70%*	$40 copay
Preventive Services**	100%	70%*	100%	60%*	100%	60%*	100%	70%*	100%
OTHER									
Therapy: Speech, Occupational and Physical (annual 60 visit limit for PPO and HDHP)	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	Only if referred through PCP, then copay
X-ray and Lab	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
Chiropractic[3] (annual 40-visit limit)	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	Only if referred through PCP, then copay
Ambulance	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	100%
Acupuncture[4] ($3,000 annual benefit)	90%*	70%*	80%*	60%*	80%*	60%*	90%*	70%*	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	Not Available
PRESCRIPTION DRUGS	**Express Scripts**		**Express Scripts**		**Express Scripts**		**Prime Therapeutics**		**Prime Therapeutics**
Retail Pharmacy (30-day supply)	$15 Generic, $40 Formulary Brand, $60 Non-Formulary Brand, $100 Specialty		$15 Generic, $40 Formulary Brand, $60 Non-Formulary Brand, $100 Specialty		$15 Generic, $40 Formulary Brand, $60 Non-Formulary Brand, $100 Specialty		80% after deductible		$15 Generic, $30 Formulary Brand, $50 Non-Formulary Brand, $50 copay for Self-injectables
Mail Order (90-day supply)	$30 Generic, $80 Formulary Brand, $120 Non-Formulary Brand, $100 Specialty		$30 Generic, $80 Formulary Brand, $120 Non-Formulary Brand, $100 Specialty		$30 Generic, $80 Formulary Brand, $120 Non-Formulary Brand, $100 Specialty		80% after deductible		$30 Generic, $60 Formulary Brand, $100 Non-Formulary Brand, $50 copay for Self-injectables
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
VISION	**VSP**		**VSP**		**VSP**		**VSP**		**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
HEARING BENEFIT	Adults: device up to $2,500/ear every 24 months / Children: device $0 cost to member, every 24 months		Adults: device up to $2,500/ear every 24 months / Children: device $0 cost to member, every 24 months		Adults: device up to $2,500/ear every 24 months / Children: device $0 cost to member, every 24 months		Adults: device up to $2,500/ear every 24 months / Children: device $0 cost to member, every 24 months		Adults: device up to $2,500/ear every 24 months / Children: device $0 cost to member, every 24 months

*Subject to deductible and coinsurance.

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

1 Deductibles are based on 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.