Medical Plans

Following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	BlueCross Blue Shield of Illinois PPO Bronze 106 HSA (239961)		BlueCross Blue Shield of Illinois PPO Silver 120 PPO (238874)		BlueCross Blue Shield of Illinois PPO Silver 133 HSA (239966)	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per Calendar Year)						
Individual / Family	$6,550 / $13,100	$12,800 / $26,200	$2,800 / $8,400	$5,600 / $16,800	$4,800 / $13,100	$9,600 / $26,200
Out-of-Pocket Maximum (per Calendar Year)						
Individual / Family	$6,550 / $13,100	$12,800 / $26,200	$7,500 / $15,000	Unlimited / Unlimited	$4,800 / $13,100	$9,600 / $26,200
Covered Services						
Office Visits (physician/specialist)	$0*	$0*	$50 / $70 copay	50%*	$0*	$0*
Routine Preventive Care	No charge	$0*	No charge	50%*	No charge	$0*
Rabies Vaccine and Rabies Titers	No charge	$0*	No charge	50%*	No charge	$0*
Outpatient Diagnostic (lab/X-ray)	$0*	$0*	40%*	50%*	$0*	$0*
Complex Imaging	$0*	$0*	$250 copay	50%*	$0*	$0*
Chiropractic [4]	$0*	$0*	40%*	50%*	$0*	$0*
Ambulance	$0*	$0*	40%*	40%*	$0*	$0*
Emergency Room	$0*	$0*	$500 copay + 40%*		$0*	$0*
Urgent Care Facility	$0*	$0*	$75 copay	50%*	$0*	$0*
Inpatient Hospital Stay	$0*	$0*	$250 copay + 40%*	$350 copay + 50%*	$0*	$0*
Outpatient Surgery	$0*	$0*	$200 copay + 40%*	$300 copay + 50%*	$0*	$0*
Prescription Drugs Preferred Generic drugs / Non-Preferred Generic drugs / Preferred Brand drugs / Non-Preferred Brand drugs / Preferred Specialty drugs / Non-Preferred Specialty drugs [2]						
Retail Pharmacy (30-day supply)	$0*	$0*	$0 / $10 / $50 / $100 / $150 / $250	$0 / $10 / $50 / $100 [5]	$0*	$0*
Mail Order [3] (90-day supply)	$0*	N/A	$0 / $30 / $150 / $300 / N/A / N/A	N/A	$0*	N/A

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents for full details.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. Please see the Summary of Benefits and Coverage for more detailed information on your prescription drug benefits.
3. Please note that for Specialty Preferred and Specialty Non-Preferred Mail Order there is only a 30 day supply available.
4. A maximum of 25 visits per calendar year.
5. For Non-Participating drug provider, you are responsible for 50% of the eligible amount after the copayment or coinsurance.

Medical Plans

Following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	BlueCross Blue Shield of Illinois PPO Gold 102 PPO (238880)		Blue Cross Blue Shield of Illinois PPO Gold 114 PPO (238877)		BlueCross Blue Shield of Illinois PPO Gold 116 PPO (238882)	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per Calendar Year)						
Individual / Family	$2,500 / $5,000	$3,000 / $9,000	$750 / $2,250	$1,500 / $4,500	$1,800 / $5,400	$3,600 / $10,800
Out-of-Pocket Maximum (per Calendar Year)						
Individual / Family	$5,000 / $10,000	Unlimited / Unlimited	$5,500 / $14,700	Unlimited / Unlimited	$4,000 / $12,000	Unlimited / Unlimited
Covered Services						
Office Visits (physician/specialist)	$20 / $60 copay	50%*	$40 / $60 copay	50%*	$20 / $40 copay	40%*
Routine Preventive Care	No charge	50%*	No charge	50%*	No charge	40%*
Rabies Vaccine and Rabies Titers	No charge	50%*	No charge	50%*	No charge	40%*
Outpatient Diagnostic (lab/X-ray)	20%*	50%*	20%*	50%*	10%*	40%*
Complex Imaging	20%*	50%*	20%*	50%*	10%*	40%*
Chiropractic [4]	20%*	50%*	20%*	50%*	10%*	40%*
Ambulance	20%*	20%*	20%*	20%*	10%*	10%*
Emergency Room	$400 copay + 20%*		$400 copay + 20%*		$400 copay + 10%*	
Urgent Care Facility	$75 copay	50%*	$75 copay	50%*	$75 copay	40%*
Inpatient Hospital Stay	$200 copay + 20%*	$300 copay + 50%*	$200 copay + 20%*	$300 copay + 50%*	$200 copay + 10%*	$300 copay + 40%*
Outpatient Surgery	$150 copay + 20%*	$250 copay + 50%*	$150 copay + 20%*	$250 copay + 50%*	$150 copay + 10%*	$250 copay + 40%*
Prescription Drugs Preferred Generic drugs / Non-Preferred Generic drugs / Preferred Brand drugs / Non-Preferred Brand drugs / Preferred Specialty drugs / Non-Preferred Specialty drugs [2]						
Retail Pharmacy (30-day supply)	$0 / $10 / $35 / $75 / $150 / $250	$0 / $10 / $35 / $75 [5]	$0 / $10 / $50 / $100 / $150 / $250	$0 / $10 / $50 / $100 [5]	$0 / $10 / $35 / $75 / $150 / $250	$0 / $10 / $35 / $75 [5]
Mail Order [3] (90-day supply)	$0 / $30 / $105 / $225 / N/A / N/A	N/A	$0 / $30 / $150 / $300 / N/A / N/A	N/A	$0 / $30 / $105 / $225 / N/A / N/A	N/A

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. Please see the Summary of Benefits and Coverage for more detailed information on your prescription drug benefits.
3. Please note that for Specialty Preferred and Specialty Non-Preferred Mail Order there is only a 30 day supply available.
4. A maximum of 25 visits per calendar year.
5. For Non-Participating drug provider, you are responsible for 50% of the eligible amount after the copayment or coinsurance.