



Medical Plan Comparison

	PPO 750		PPO 1200		HDHP — PPO 1650 ⁵		HMO 30	BA HMO 30
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	HMO Illinois Network	Blue Advantage HMO Network
DEDUCTIBLE ¹								
Individual	\$750	\$1,500	\$1,200	\$2,400	\$1,650 ⁵		N/A	N/A
Family	\$1,500	\$3,000	\$2,400	\$4,800	\$3,300 ^{3,5}		N/A	N/A
COINSURANCE	80%	60%	80%	60%	90%	70%	100%	100%
OUT-OF-POCKET LIMIT ¹								
Individual	\$3,800	\$6,800	\$4,250	\$7,700	\$6,350 ⁵		\$1,500	\$1,500
Family	\$7,600	\$13,600	\$8,500	\$15,400	\$12,700 ^{4,5}		\$3,000	\$3,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	Unlimited
HOSPITAL SERVICES								
Hospital Inpatient Admission (annual 5 visit limit)	\$150 copay then 80%*	\$150 copay then 60%*	\$150 copay then 80%*	\$150 copay then 60%*	90%*	70%*	100%	100%
Inpatient Services	80%*	60%*	80%*	60%*	90%* (\$125 on average)	70%*	100%	100%
Outpatient Services	80%*	60%*	80%*	60%*	90%*	70%*	100%	100%
Emergency Room	\$150 copay then 90%*; inpatient copay applies if admitted		\$150 copay, then 90%*; inpatient copay applies if admitted		90%*		\$150 copay; copay waived if admitted	\$150 copay; copay waived if admitted
PHYSICIAN SERVICES								
Inpatient Surgery	80%*	60%*	80%*	60%*	90%*	70%*	100%	100%
Outpatient Surgery	80%*	60%*	80%*	60%*	90%*	70%*	100%	100%
Primary Care Office Visits	\$30 copay	60%*	\$30 copay	60%*	90%*	70%*	\$30 copay	\$30 copay
Specialist Office Visits	\$50 copay	60%*	\$50 copay	60%*	90%*	70%*	\$50 copay	\$50 copay
Preventive Service**	100%*	60%*	100%	60%*	100%	70%*	100%	100%
Virtual Visits	\$10 copay	N/A	\$10 copay	N/A	\$44 on average then 90%*	N/A	Check with your Medical Group	Check with your Medical Group
OTHER								
X-ray and Lab	80%*	60%*	80%*	60%*	90%*	70%*	100%	100%
Chiropractic ¹ (annual 35 visit limit for PPO and HDHP)	80%*	60%*	80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
Ambulance	80%*	60%*	80%*	60%*	90%*	70%*	100%	100%
Therapy: Occupational, Physical or Speech ¹ (annual 60 visit limit for PPO and HDHP)	80%*	60%*	80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
Acupuncture ¹ (\$3,000 annual benefit for PPO and HDHP)	80%*	60%*	80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
PRESCRIPTION DRUGS	Prime Therapeutics		Prime Therapeutics		Prime Therapeutics		Prime Therapeutics	Prime Therapeutics
Retail Pharmacy (30-day supply)	\$10 Generic; \$25 Preferred Brand; \$50 Non-Preferred Brand		\$10 Generic; \$25 Preferred Brand; \$50 Non-Preferred Brand		80%*		\$20 Generic \$40 Preferred Brand \$70 Non-Preferred Brand \$70 Self-Injectables	\$20 Generic \$40 Preferred Brand \$70 Non-Preferred Brand \$70 Self-Injectables
NEW! Pharmacy or Mail Order (90-day supply)	\$20 Generic; \$50 Preferred Brand; \$100 Non-Preferred Brand		\$20 Generic; \$50 Preferred Brand; \$100 Non-Preferred Brand		80%*		\$40 generic \$80 Preferred Brand \$140 Non-Preferred Brand \$70 Self-Injectables	\$40 Generic \$80 Preferred Brand \$140 Non-Preferred Brand \$70 Self-Injectables
Prescription Out-of-Pocket Limits (Individual/Family)	\$2,750 / \$5,500		\$2,750 / \$5,500		Integrated with Medical		\$1,000 / \$2,000	\$1,000 / \$2,000
VISION	VSP		VSP		VSP		EyeMed	EyeMed
Annual Vision Exam	\$10 copay	Reimbursed up to \$45	\$10 copay	Reimbursed up to \$45	100% after \$10 copay	Reimbursed up to \$45	100%	100%
Hearing Benefit	Adults: 90*; one device every 24 months Children: device \$0 cost to member, every 24 months		Adults: 90*; one device every 24 months Children: device \$0 cost to member, every 24 months		Adults: 90*; one device every 24 months Children: device \$0 cost to member, every 24 months		Adults: one device every 24 months Children: device \$0 cost to member, every 24 months	Adults: one device every 24 months Children: device \$0 cost to member, every 24 months

¹Subject to deductible.

²As directed by the U.S. preventive task force

³Deductible, Out-of-Pocket, Chiropractic, Acupuncture, and therapy limits are based on a calendar year.

⁴Chiropractic care that is medically necessary is covered, maintenance care is not covered.

⁵If you are covering dependents and enrolled in the HDHP plan you must meet the family deductible prior to coinsurance.

⁶If 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.

⁷Annually, The Department of Health and Human Services (HHS) establishes annual out-of-pocket or cost-sharing limits under the ACA for essential health benefits covered under an ACA-compliant plan.