CCSD 62

BCBS Health Care Plan Administrator

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

Individual deductible and out-of-pocket pertains to the single tier. Family deductible and out-of-pocket pertains to the employee+spouse, employee+child(ren), and family tiers

	HMO Illinois	PPO Plan 500		PPO Plan 750		HDHP Plan 1500	
		In Network	Out-Of-Network	In Network	Out-Of-Network	In Network	Out-Of-Network
Lifetime Maximum	Unlimited	Unlimited		Unlimited		Unlimited	
Deductible[1]							
Individual	N/A	$500	$1,000	$750	$1,500	$1,500	
Family	N/A	$1,500	$3,000	$2,100	$4,200	$3,000	
Coinsurance	100%	90%	70%	90%	70%	90%	70%
Out-of-pocket limit[3]							
Individual	$1,500	$1,500	$3,000	$2,250	$4,500	$5,950	
Family	$3,000	$3,000	$6,000	$4,500	$9,000	$7,150	
Covered Expenses							
Hospital							
Inpatient Services	100%	90%*	70%*	90%*	70%*	90%*	70%*
Outpatient Services	100%	90%*	70%*	90%*	70%*	90%*	70%*
Emergency Room	$75 copay Copay waived if admitted	$75 copay, then 90%*. Copay waived if admitted		$75 copay, then 90%*. Copay waived if admitted		90%*	
Physician							
Inpatient Surgery	100%	90%*	70%*	90%*	70%*	90%*	70%*
Outpatient Surgery	100%	90%*	70%*	90%*	70%*	90%*	70%*
Primary Care Visits	$20 copay[2]	$20 copay[2]	70%*	$20 copay[2]	70%*	90%*	70%*
Specialist Visits	$40 copay[2]	$40 copay[2]	70%*	$40 copay[2]	70%*	90%*	70%*
Wellcare/Physical Exam[4]	100%	100%	70%*	100%	70%*	100%	70%*
MDLive Virtual Visits	Not Available	$20 copay	N/A	$20 copay	N/A	90%*	N/A
Other							
X-ray and Lab	100%	90%*	70%*	90%*	70%*	90%*	70%*
Chiropractic	Copay, only if referred through PCP	90%* 30 visits per calendar year	70%* 30 visits per calendar year	90%* 30 visits per calendar year	70%* 30 visits per calendar year	90%* 30 visits per calendar year	70%* 30 visits per calendar year
Therapy: Occupational, Physical or Speech	Copay only if referred through PCP, 60 combined treatments limit	90%*	70%*	90%*	70%*	90%*	70%*
Prescription Drugs							
Retail Pharmacy[2]	$10 Generic $35 Formulary Brand $60 Non-Formulary Brand	$10 Generic, $35 Formulary Brand, $60 Non-Formulary Brand		$10 Generic, $35 Formulary Brand, $60 Non-Formulary Brand		90%*	
Mail Order[2]	$20 Generic $70 Formulary Brand $120 Non-Formulary Brand	$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand		$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand		90%*	
Prescription Out-of-Pocket Limit (Single/Family)	$1,000/$2,000	$1,000/$2,000		$1,000/$2,000		Combined with Medical	
Vision Benefit	Vision exam every 12 months; $150 contact lens allowance every 24 months; $225 frame allowance every 24 months	$30 allowance towards vision exam every 12 months; $200 materials allowance every 12 months		$30 allowance towards vision exam every 12 months; $200 materials allowance every 12 months		Not covered	

1 Deductibles are based on calendar year.

2 Copays are applied towards the out-of-pocket limit. Copays are not applied towards the deductible.

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.

3 The out-of-pocket limit includes the deductible.

4 Applies to both adults and children, as defined by the US preventive task force.

* After deductible