## Looking for Health and Wellness Information? Try:

**Blue Cross & Blue Shield of Illinois: www.bcbsil.com**
**WebMD: www.mywebmd.com**
**Mayo Clinic: www.mayoclinic.com**
**Healthfinder: www.healthfinder.gov**
**Women's Health: www.ivillage.com**

## PHYSICIAN NETWORK ACCESS:

***LOG ONTO: WWW.BCBSIL.COM***

Click on **"Provider Finder"**. Under the **"Group Products"** choose **"PPO (Participating Provider Option)"**. Search for Providers by; **your home zip code; provider specialty; or provider name.**

Medical and Prescription Drugs Benefits are insured by:

BlueCross BlueShield of Illinois

| Plan Effective Date: January 1, 2024 | Active PPO Network Benefits | Active PPO Non-Network Benefits |
|---|---|---|
| **PCP Office Visit** | $20 copay | 60% after Deductible |
| **Specialist Office Visit** | $40 copay | 60% after Deductible |
| **Deductible** | | |
| Individual | $500 | $1,500 |
| Family | $1,000 | $3,000 |
| **Coinsurance** | Plan Pays 80% | Plan Pays 60% |
| **Out-of-Pocket Maximum** | | |
| Individual (Includes Deductible) | $1,800 | $5,400 |
| Family (Includes Deductible) | $3,600 | $10,800 |
| **Retail Prescription Drugs** | ***30 Day Supply (100 unit maximum x 2 copays)*** | |
| Generic Formulary | $10 | $10 plus 25% Coinsurance |
| Brand Formulary | $30 | $35 plus 25% Coinsurance |
| Non-Formulary | $50 | $50 plus 25% Coinsurance |
| **Mail Order Prescription Drugs** | ***90 Day Supply*** | |
| Generic Formulary | $10 | N/A |
| Brand Formulary | $30 | N/A |
| Non-Formulary | $50 | N/A |
| **Preventive Care (Includes):** Health Ed/Counseling Services, Immunizations, Routine Bone Density Test, Routine Breast Exam, Routine Colonoscopy, Routine Colorectal Cancer Screening-Lab, Routine Digital Rectal Exam, Routine Gynecological Exam, Routine Lab Procedures, Routine Mammogram, Routine Pap Smear, Routine Physical Exam, Routine Prostate Test, Smoking Cessation Program | 100%, no copay<br>*Benefit includes 1st mammogram per year regardless of diagnosis. Mammograms thereafter with a routine diagnosis, will be covered at 100%. Mammograms thereafter with a medical diagnosis, will be subject to normal deductibles and co-insurance levels.* | 60% after Deductible |
| **Diagnostic Lab and X-Ray** | 80% after Deductible | 60% after Deductible |
| **Outpatient Surgery** | 80% after Deductible | 60% after Deductible |
| **Hospital Services (In-Patient)** | 80% after Deductible (Pre-Cert required) | 60% after Deductible |
| **Out-Patient Services** | 80% after Deductible | 60% after Deductible |
| **Maternity Services** | 80% after Deductible | 60% after Deductible |
| **Emergency Room Services** | 80% after Deductible | 80% after Deductible |
| **Mental/Nervous/Sub. Abuse** | | |
| InPatient | 80% after Deductible | 60% after Deductible |
| OutPatient | 80% after Deductible | 60% after Deductible |
| **Chiropractic** | 80% after Deductible<br>$1000 ann max on manipulations<br>Other Chiro services, no max. | 60% after Deductible |

## MetLife Dental

*Indemnity Plan*

| | |
|---|---|
| **Benefit Maximum** | **$1,500 per Year** |
| **Individual Deductible:** | **$50 per Calendar Yr.** |
| **Family Deductible:** | **$150 per Calendar Yr.** |
| **Orthodontia** | **Not Covered** |

| **Preventive and Diagnostic Care** | **100% of U & C Fee (Deductible is waived)** |
|---|---|

Two Oral Exams per calendar year.
Prophylaxis limited to two cleanings per calendar year.
Flouride Treatments for Dependents under age 19, limited to 2 per calendar year.
Dental X-Rays including bitewing 1 in 12 months and full mouth x-rays limited to one per 5 years.
Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

| **Basic and Primary Dental Care** | **80% of U & C Fee (Deductible Applies)** |
|---|---|

Fillings, Extractions, Oral Surgery, Endodontics, Pulp Vitality Tests, Periodontics/Periodontal Therapy, Gingivectomy and Gingivoplasty, Periodontal Maintenance Procedures, Repair of Complete or Partial Dentures, Repair and Relining of Complete or Partial Dentures, Replacement Dentures (subject to pre-existing conditions limitations) if; repaired due to removal of natural teeth; or the initial placement of an opposing full denture, (replacement of dentures for any other reason will be covered under Major Services) and Prescriptions Drugs dispensed by a licensed pharmacist. See Benefit booklet for complete details.

| **Major Dental Services** | **50% of U & C Fee (Deductible Applies)** |
|---|---|

Inlays, Onlays, Crowns (other than temporary crowns and stainless steel crowns), Fixed Bridgework, Bridge Repairs, Full and Partial Denture, Denture Adjustments, Rebasing and Relining during the first 6 months after obtaining dentures, Recementing of Crowns, Inlays, Onlays and Bridges. Benefits for crowns, inlays, onlays, bridges or denture replacement are not covered until 10 years have lapsed. Implants are not covered. See Benefit booklet for complete details.

***Calendar Year Means 01/01 through 12/31.***
***U & C Fee Means the usual and customary charges as established by the prevailing charge by providers and suppliers in a geographic location.***

***The Benefit guide only highlights the benefits available. For a more complete description, see the Summary Plan Description. If any conflict should arise between this summary and the Summary Plan Description, the Summary Plan Description will govern in all cases.***