

# Medical Plan Options

For details and limitations, please refer to your summary of benefits for specific requirements regarding pre-authorizations, coverage limits, and out-of-network costs.

BCBS	MIBCS2050 Blue Choice PPO (Emb)	MIBCO2000 Blue Choice Options (Emb)	MIBAH2020 HMO (Emb)
Network	Blue Choice Select (Narrow Network)	Blue Choice Options (Tiered Network)	BlueAdvantage HMO
Website	www.bcbsil.com	www.bcbsil.com	www.bcbsil.com

Illinois Only Plan

PCP Selection Required  
(Illinois Only Plan)

In-Network	You Pay	You Pay	You Pay
		Blue Choice - Tier 1	PPO - Tier 2

Plan Year Deductible (Individual / Family)	\$1,000 / \$3,000	\$500/\$1,500 (BC)	\$1,500/\$4,500 (PPO)	\$0 / \$0
Coinsurance (Plan Pays / Member Pays)	80/20	90/10 (BC)	70/30 (PPO)	100/0
Out-of-Pocket Max <sup>+</sup> (Individual / Family)	\$3,000 / \$9,000	\$4,000/\$10,200 (BC)	\$5,600/\$10,200 (PPO)	\$1,500 / \$3,000
Primary Care / Specialist Office Visit	\$30 / \$30	\$20 / \$40 (BC)	\$50 / \$100 (PPO)	\$20 / \$40
Urgent Care Facility	20% after Ded	\$75 then 0%	\$75 then 0%	\$40 then 0%
Emergency Room Care	\$200 then 0%	\$400 then Ded/Coins		\$250 then 0%
Inpatient Hospital	20% after Ded	\$250 (BC) then Ded/Coins	\$500 (PPO) then Ded/Coins	0% after Ded
Outpatient Surgery	20% after Ded	\$200 (BC) then Ded/Coins	\$400 (PPO) then Ded/Coins	0% after Ded

Prescription	You Pay	You Pay	You Pay
Retail (up to 30-day supply)	\$0/\$10/\$35/\$75/\$150/\$250***	\$0/\$10/\$35/\$75/\$150/\$250***	\$0/\$10/\$50/\$100/\$150/\$250

Out-of-Network	You Pay	You Pay	You Pay
Plan Year Deductible (Individual / Family)	\$2,000 / \$6,000	\$3,000 / \$9,000	
Coinsurance (Plan Pays / Member Pays)	50/50	50/50	N/A
Out-of-Pocket Max <sup>+</sup> (Individual / Family)	\$9,000 / \$27,000	\$16,800 / \$30,600	

\*\*\*Copays/Coins shown are for BCBS Preferred Pharmacy (includes Osco, Walgreens, Walmart). Higher Copays/Coins applies for Non-Preferred Pharmacy

Limitations and maximums may apply. Please refer to the plan summaries and Summary of Benefits and Coverage for more information.

\*Plan Year Out-of-Pocket Maximum includes deductibles, copays and coinsurance

# Medical Plan Options

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BCBS	MIESA2122 BlueEdge Select HSA (Agg)	MICOE4065 Blue Choice Options HSA (Emb)
Network	BlueEdge Select (Narrow Network)	Blue Choice Options (Tiered Network)
Website	www.bcbsil.com	www.bcbsil.com

In-Network	You Pay	You Pay
		Blue Choice - Tier 1 PPO - Tier 2

Plan Year Deductible (Individual / Family)	\$2,500 / \$5,000	\$3,500/\$10,500 (BC)	\$4,600/\$13,800 (PPO)
Coinsurance (Plan Pays / Member Pays)	100/0	100/0 (BC)	80/20 (PPO)
Out-of-Pocket Max <sup>+</sup> (Individual / Family)	\$2,500 / \$5,000	\$3,500/\$10,500 (BC)	\$6,550/\$19,650 (PPO)
Primary Care / Specialist Office Visit	0% after Ded	0% after Ded (BC)	20% after Ded (PPO)
Urgent Care Facility	0% after Ded	0% after Ded (BC)	20% after Ded (PPO)
Emergency Room Care	0% after Ded	0% after Ded	
Inpatient Hospital	0% after Ded	0% after Ded (BC)	20% after Ded (PPO)
Outpatient Surgery	0% after Ded	0% after Ded (BC)	20% after Ded (PPO)

Prescription	You Pay	You Pay
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Retail (up to 30-day supply)	0% after Ded	0% after Ded
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Out-of-Network	You Pay	You Pay
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Plan Year Deductible (Individual / Family)	\$5,000 / \$10,000	\$10,500 / \$31,500
Coinsurance (Plan Pays / Member Pays)	100/0	60/40
Out-of-Pocket Max <sup>+</sup> (Individual / Family)	\$5,000 / \$10,000	\$19,650 / \$42,000

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\*Plan Year Out-of-Pocket Maximum includes deductibles, copays and coinsurance