ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303

2024 Benefits at a Glance

Medical Insurance

BlueCross BlueShield of Illinois

MEDICAL COVERAGE HIGHLIGHTS	PPO		CDHP		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
ANNUAL DEDUCTIBLE					
Single	$500	$1,000	$2,000	$4,000	N/A
Single + 1	$1,000	$2,000	N/A	N/A	N/A
Family	$1,500	$3,000	$4,000	$8,000	N/A
COINSURANCE (percent paid after you reach your annual deductible)					
Plan Pays	80%	70%	80%	60%	100%
You Pay	20%	30%	20%	40%	0%
ANNUAL OUT-OF-POCKET MAXIMUM					
Single	$4,500	$9,000	$7,000	$14,000	$1,500
Single + 1	$9,000	$18,000	N/A	N/A	N/A
Family	$13,500	$27,000	$12,000	$24,000	$3,000
COVERED SERVICES (what you will pay)					
Preventative Care	No charge	10% coinsurance	No charge	10% coinsurance	No charge
Primary Care Office Visit	$25 copay	30% coinsurance	20% coinsurance	40% coinsurance	$25 copay
Specialist Office Visit	$50 copay	30% coinsurance	20% coinsurance	40% coinsurance	$50 copay
Urgent Care	$25 copay	30% coinsurance	20% coinsurance	40% coinsurance	$25 copay
Emergency Room	$100 copay + 20% coinsurance		20% coinsurance		$100 copay
Hospitalization	20% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	$200 copay per day up to 3 days per calendar year
RETAIL PRESCRIPTION DRUG COVERAGE HIGHLIGHTS					
Generic	$10 copay	$10 copay + 25%	$10 copay*	$10 copay + 25%*	$10 copay
Preferred Brand	$30 copay	$30 copay + 25%	$25 copay*	$25 copay + 25%*	$30 copay
Non-Preferred Brand	$80 copay	$80 copay + 25%	$60 copay*	$60 copay + 25%*	$80 copay
Self-Injectables	$65 copay	$65 copay + 25%	$65 copay*	$65 copay + 25%*	$65 copay
Specialty	$200 copay	Not covered	$60 copay*	Not covered	$200 copay

*Subject to deductible then copays apply. Approved preventative medications are paid prior to deductible as the listed copays.

Dental Insurance

MetLife

DENTAL COVERAGE HIGHLIGHTS	In-Network % of Negotiated Fee	Out-of-Network 90% of Reasonable & Customary
Annual Deductible Individual Family	$50 $150	$50 $150
Annual Benefit Maximum Per Person	$1,750	$1,750
Orthodontia Lifetime Maximum Per Person	$1,500	$1,500
Implant Annual Maximum Per Person	$1,000	$1,000
Preventative Care Oral exams, cleanings, x-rays, etc.	100%	75%
Basic Services Root canals, fillings, simple extractions, etc.	85%	60%
Major Services Crowns, inlays, onlays, dentures, etc.	55%	30%
Orthodontia Services	50%	50%

Vision Insurance

VSP

VISION COVERAGE HIGHLIGHTS	In-Network VSP Signature Network	Out-of-Network
Exam Once every 12 months	$10 copay	Reimbursed up to $45
Prescription Glasses	$25 copay	See Frame and Lenses
FRAMES		
Frames Once Every 24 months • $150 allowance for a wide selection of frames • $170 for featured frames • 20% savings on the amount over your allowance • $70 Walmart / Sam's Club / Costco frame allowance	Included in Prescription Glasses up to the limits listed to the left	Reimbursed up to $70
Lenses Once every 12 months • Single vision / lined bifocal / lined trifocal / lenticular	Included in Prescription Glasses	Reimbursed up to $30 / $50 / $65 / $100
Lens Enhancements Once every 12 months • Standard progressive • Premium progressive • Custom progressive	$0 copay $80 - $90 copay $120 - $160 copay	Reimbursed up to $45 Reimbursed up to $45 Reimbursed up to $45
Contact Lenses Once every 12 months; in lieu of lenses / frames glasses $150 allowance for contacts and contact lens exam (fitting and evaluation)	$0	Reimbursed up to $105
Diabetic Eyecare Plus Program (as needed) • Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD) • Retinal screening for eligible Members with diabetes Limitations and coordination with medical coverage may apply. Ask your VSP Doctor for details.	$0 $20 per exam	N/A

The information described within this document is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your plan booklets (Health Care Benefit Program, Program Description, Evidence of Coverage and Program Summaries) for a complete explanation of your benefits. If the benefits described herein conflict in any way with the plan booklets, the plan booklets will prevail. You can obtain a copy of the plan booklets from the Benefits Coordinator. The D303 Benefits Coordinator can be reached at 331.228.6832.