

Plan Feature	HMO A HMO Illinois Group #: H56154	HMO B Blue Advantage Group #: B56153	PPO 1000 Group #: PI4868		PPO 1250 Group #: PM3194		HSA 3300 PPO Group #: PI4869	
	In-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE								
Employee Only	\$0	\$0	\$1,000	\$2,000	\$1,250	\$2,500	\$3,300	\$3,300
Family	\$0	\$0	\$2,000	\$4,000	\$2,500	\$5,000	\$6,600	\$6,600
ANNUAL OUT-OF-POCKET MAXIMUM								
Employee Only	\$1,500	\$1,500	\$4,000	\$8,000	\$5,000	\$10,000	\$3,300	\$6,000
Family	\$3,000	\$3,000	\$8,000	\$16,000	\$10,000	\$20,000	\$6,600	\$12,000
OFFICE VISIT								
Primary Care Physician	\$25 copay	\$20 copay	\$25 copay	Plan pays 60% after deductible is met	\$25 copay	Plan pays 60% after deductible is met	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
Specialist	\$50 copay	\$40 copay	\$50 copay	Plan pays 60% after deductible is met	\$50 copay	Plan pays 60% after deductible is met	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Emergency Room (copay waived if admitted)	\$150 copay, then plan pays 100%	\$50 copay, then plan pays 100%	\$200 copay, then plan pays 100%, no deductible		\$200 copay, then plan pays 100%, no deductible		Plan pays 100% after deductible is met	
Inpatient Hospital Stay	100% after \$150 copay for first 3 days	Plan pays 100%	Plan pays 80%, no deductible	Plan pays 60%, no deductible	Plan pays 80%, no deductible	Plan pays 60%, no deductible	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
PRESCRIPTION DRUGS								
Retail (Up to a 30-day supply)	Generic \$15 Preferred \$30 Non-Preferred \$60	Generic \$5 Preferred \$25 Non-Preferred \$50 Specialty \$50	Generic \$10 Preferred \$40 Non-Preferred \$60 Specialty \$60		Generic \$10 Preferred \$40 Non-Preferred \$60 Specialty \$60		Plan pays 100% after deductible is met	
Mail Order (Up to a 90-day supply)	Generic \$30 Preferred \$60 Non-Preferred \$120	Generic \$10 Preferred \$50 Non-Preferred \$100	Generic \$20 Preferred \$80 Non-Preferred \$120		Generic \$20 Preferred \$80 Non-Preferred \$120		Plan pays 100% after deductible is met	