Medical Plan Comparison

	PPO 300		PPO 750	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
DEDUCTIBLE[1]				
Individual	$300	$900	$750	$1,500
Family	$600	$1,800	$1,500	$3,000
COINSURANCE	80%	60%	80%	60%
OUT-OF-POCKET LIMIT[1]				
Individual	$2,200	$4,400	$3,400	$6,800
Family	$4,400	$8,800	$6,800	$13,600
Lifetime Maximum	Unlimited		Unlimited	
HOSPITAL				
Inpatient Services	80%*	60%*	80%*	60%*
Outpatient Services	80%*	60*	80%*	60%*
Emergency Room	$100 copay then 90%* copay waived if admitted		$100 copay, then 90%*; copay waived if admitted	
PHYSICIAN				
Inpatient Surgery	80%*	60%*	80%*	60%*
Outpatient Surgery	80%*	60%*	80%*	60%*
Primary Care Office Visits	$20 copay	60%*	$20 copay	60%*
Specialist Office Visits	$40 copay	60%*	$40 copay	60%*
Virtual Visits	$10 copay	N/A	$10 copay	N/A
Preventive Services**	100%	60%*	100%	60%*
OTHER				
X-ray and Lab	80%*	60%*	80%*	60%*
Chiropractic[2] (annual 40 visit limit)	80%*	60%*	80%*	60%*
Ambulance	80%*	60%*	80%*	60%*
Therapy: Occupational, Physical or Speech (annual 60 visit limit)	80%*	60%*	80%*	60%*
Acupuncture ($3,000 annual benefit)	80%*	60%*	80%*	60%*
PRESCRIPTION DRUGS				
Retail Pharmacy (30-day supply)	$10 Generic $20 Brand		$10 Generic $20 Brand	
Mail Order (90-day supply)	$15 Generic $25 Brand		$15 Generic $25 Brand	
Prescription Out-of-Pocket Limits (Single/Family)	$2,750/$5,500		$2,750/$5,500	
Vision				
Vision Exam	$10 copay with VSP	Reimbursed to $45 with VSP	$10 copay with VSP	Reimbursed to $45 with VSP

NEW!

[1] Deductibles and Out-of-Pocket Limit are based on calendar year.

[2] Chiropractic care that is medically necessary is covered, maintenance care is not covered.

*Subject to deductible

**As defined by the US Preventive Task Force

PPO 1200		PPO 200		HMO 20
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**HMO Illinois Network**
$1,200	$2,400	$200	$500	N/A
$2,400	$4,800	$400	$1,000	N/A
80%	60%	90%	70%	100%
$3,850	$7,700	$1,300	$3,900	$1,500
$7,700	$15,400	$2,600	$7,800	$3,000
Unlimited		Unlimited		Unlimited
80%*	60%*	90%*	70%*	100%
80%*	60%*	90%*	70%*	100%
$100 copay, then 90%*; copay waived if admitted		$100 copay, then 90%*, copay waived if admitted		$100 copay copay waived if admitted
80%*	60%*	90%*	70%*	100%
80%*	60%*	90%*	70%*	100%
$20 copay	60%*	$20 copay	70%*	$20 copay
$40 copay	60%*	$40 copay	70%*	$40 copay
$10 copay	N/A	$10 copay	N/A	N/A
100%	60%*	100%	70%*	100%
80%*	60%*	90%*	70%*	100%
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay
80%*	60%*	90%*	70%*	100%
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay
$10 Generic $20 Brand		$10 Generic $20 Brand		$15 Generic; $30 Formulary Brand; $50 Non-Formulary Brand $50 Self-injectables
$15 Generic $25 Brand		$15 Generic $25 Brand		$30 Generic; $60 Formulary Brand; $100 Non-Formulary Brand $50 Self-injectables
$2,750/$5,500		$2,750/$5,500		$1,000/$2,000
$10 copay with VSP	Reimbursed to $45 with VSP	$10 copay with VSP	Reimbursed to $45 with VSP	100% through EyeMed or Davis Vision