



Medical Plan Comparison

	PPO 300		PPO 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE¹				
Individual	\$300	\$900	\$750	\$1,500
Family	\$600	\$1,800	\$1,500	\$3,000
COINSURANCE				
	80%	60%	80%	60%
OUT-OF-POCKET LIMIT¹				
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%
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				
	Express Scripts		Express Scripts	
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

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
	Express Scripts		Express Scripts		Prime Therapeutics
	\$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