

TYPE OF COVERAGE	HMO ILLINOIS Medicare - Non-Medicare	CLASSIC BLUE CROSS HMO Medicare - Non-Medicare	BLUE CROSS Non-Medicare	BLUE CROSS Medicare	BLUE CROSS Out of Network
Annual Deductible	None	None	\$125 Individual \$250 Family	\$125 Individual \$250 Family	\$250 Individual \$500 Family
OUT-OF-POCKET	\$1500 Individual \$3000 Family	\$1500 Individual \$3000 Family	\$650 Individual \$1000 Family	\$650 Individual \$1000 Family	\$5000 Individual \$10,000 Family
LIFETIME MAXIMUM	Unlimited	Unlimited	\$1,000,000.00	\$1,000,000.00	\$1,000,000.00
EMERGENCY CARE					
Emergency room	\$100 Copay - waived if admitted	\$100 Copay -waived if admitted	90% after deductible	90% after deductible	70% after deductible
Ambulance	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
Care when out of service area	\$100 copay - waived if admitted	\$100 Copay -waived if admitted	90% after deductible	90% after deductible	70% after deductible
IN THE HOSPITAL					
Inpatient Care	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
Room & Board	\$100 Copay per admission	\$100 Copay per admission	90% after deductible	90% after deductible	70% after deductible
Surgeon's Fees	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
Doctor's visits	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
Medications	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
IN THE DOCTOR'S OFFICE					
Routine Physical Exam	\$10 Copay	\$10 Copay	90% after deductible	90% after deductible	70% after deductible
Follow-up Visit	\$10 Copay	\$10 Copay	90% after deductible	90% after deductible	70% after deductible
Specialist	\$20 Copay	\$20 Copay	90% after deductible	90% after deductible	70% after deductible
Diagnostic Test and X-rays	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
Immunizations	\$10 Copay	Covered in full	90% after deductible	90% after deductible	70% after deductible
Wellness	\$10 Copay	Covered in full	90% after deductible	90% after deductible	70% after deductible
MEDICAL SERVICES					
Outpatient Surgery	\$100 Copay	Covered in full	90% after deductible	90% after deductible	70% after deductible
Mental Health -Outpatient	\$20 Copay	\$25 Copay	90% after deductible	90% after deductible	70% after deductible
Mental Health -Inpatient	\$100 Copay	\$100 Copay	90% after deductible	90% after deductible	70% after deductible
Substance Abuse-Outpatient	\$10 Copay	Covered in full - 20 visits/calendar year	90% after deductible	90% after deductible	70% after deductible
Substance Abuse-Inpatient	\$100 Copay - 20 days/calendar year	\$100 Copay - max 30 days/calendar year	90% after deductible	90% after deductible	70% after deductible
HOSPITAL ALTERNATIVES					
Skilled Nursing	Covered in full	Covered in full. 100 days/calendar year	90% 120 days per calendar year	50% 120 days per calendar year	70% 120 days per calendar year
Hospice	Covered in full	Up to \$10,000 per period of care	90% after deductible	90% after deductible	70% after deductible
Home Health Care	Covered in full	Covered in full 60 visits/calendar year	90% after deductible	90% after deductible	70% after deductible
DURABLE MEDICAL EQUIPMENT	Covered in full	Covered in full	90% after deductible	90% after deductible	70% after deductible
EYE EXAMS	\$75 Allowance every 24 months	\$75 Allowance every 24 months	Discounts on Exams, Lenses & Frames	Discounts on Exams, Lenses & Frames	Discounts on Exams, Lenses & Frames
PRESCRIPTION PLAN	30-Day Supply at Retail: \$5 Generic / \$25 Preferred Brand / \$40 Non-Preferred Brand		90-Day Supply at CVS Retail or Caremark Mail: \$10 Generic / \$40 Preferred Brand / \$75 Non-Preferred Brand		