

IN-NETWORK

General Coverage Comparison for All Medical Plans ^{1,2}

	BlueEdge HSA	BCBS PPO	HMO Illinois
Employer HSA Contribution	\$500 single; \$1,000 >single	n/a	n/a
Lifetime Maximum	Unlimited	\$3,000,000*	Unlimited
Annual Deductible	\$1,200 single; \$2,400 >single	\$200/person; \$400/family	\$0
Annual Out-of-Pocket Maximum (Deductible plus Co-insurance)	\$3,000 single; \$6,000 >single	\$1,200/person; \$2,400/family	\$1,500/person; \$3,000/family (excludes Rx and Vision co-pay)
PCP Required	No	No	Yes
Office Visit Co-Pay / Co-insurance	10%	\$20 ⁴	\$20
In-patient Hospital Services	10%	10%	\$0
Rx – Retail (up to a 30-day supply)	10% (Generic, Formulary, & Brand) ⁴	30% (Generic, Formulary, & Brand) ^{3,4} \$10 minimum, \$75 maximum	Generic: \$10 Formulary: \$20 Brand: \$35 Self-injectable: \$50
Rx – Mail Order (up to a 90-day supply)	10% (Generic, Formulary, & Brand) ⁴	Generic: \$15 ^{3,4} Formulary: \$30 ^{3,4} Brand: \$40 ^{3,4}	Generic: \$20 Formulary: \$40 Brand: \$70 Self-injectable: \$50
Emergency Room	10%	10%	\$75 (waived if admitted)
Mental Health / Substance Abuse Treatment	Paid the same as any other condition	Paid the same as any other condition	Out-patient: \$20 co-pay per visit. In-patient: 100%.

*Combined in-and-out-of-network

Preventive Care Coverage Detailed Comparison ^{1,2}

	BlueEdge HSA	BCBS PPO	HMO Illinois
Well Child Care ⁵			
Routine Immunizations:	Yes	Yes	Yes
Routine Physical Examinations:	Yes	Yes	Yes
Routine Diagnostic Tests:	Yes	Yes	Yes
Deductible:	No	No	No
Co-insurance (% of bill paid by you):	0%	0%	0%
Limits on Frequency of Testing:	None	None	Yes ⁶
Doctor Office Co-payment:	\$0	\$0	\$20
Annual Maximum:	None	None	None
Wellness Care ⁵			
Routine Immunizations:	Yes	Yes	Yes
Routine Physical Examinations:	Yes	Yes	Yes
Routine Diagnostic Tests:	Yes	Yes	Yes
Routine Gynecological Examinations:	Yes	Yes	Yes
Routine Mammograms:	Yes	Yes	Yes
Colorectal Cancer Screening and Colonoscopies:	Yes	Yes ⁷	Yes
Routine Prostate-related Testing:	Yes	Yes	Yes
Deductible:	No	No	No
Co-insurance (% of bill paid by you):	0%	0%	0%
Limits on Frequency/Type of Preventive Care Services:	None	Yes ⁷	Yes ⁶
Annual Maximum:	None	None	None
Doctor Office Co-payment:	\$0	\$0	\$20

OUT-OF-NETWORK

General Coverage Comparison for All Medical Plans ^{1,2}

	BlueEdge HSA	BCBS PPO	HMO Illinois
Employer HSA Contribution	\$500 single; \$1,000 >single	n/a	n/a
Lifetime Maximum	Unlimited	\$3,000,000*	n/a
Annual Deductible	\$2,400 single; \$4,800 >single	\$400/person; \$800/family	n/a
Annual Out-of-Pocket Maximum (Deductible plus Co-insurance)	\$6,000 single; \$12,000 >single	\$2,400/person; \$4,800/family	n/a
PCP Required	No	No	Not Covered
Office Visit Co-Pay / Co-insurance	30%	30%	Not Covered
In-patient Hospital Services	30%	30%	Not Covered
Rx – Retail (up to a 30-day supply)	25% (Generic, Formulary, & Brand) ⁴	30% (Generic, Formulary, & Brand) ^{3,4} \$10 minimum, \$75 maximum	Not Covered
Rx – Mail Order (up to a 90-day supply)	Not Covered	Not Covered	Not Covered
Emergency Room	10% (30% for non-emergency)	10%	\$75 (waived if admitted)
Mental Health / Substance Abuse Treatment	Paid the same as any other condition	Paid the same as any other condition	Not Covered

*combined in-and-out-of network

Preventive Care Coverage Detailed Comparison ^{1,2}

	BlueEdge HSA	BCBS PPO	HMO Illinois
Well Child Care ⁵			
Routine Immunizations:	Yes	Yes	n/a
Routine Physical Examinations:	Yes	Yes	n/a
Routine Diagnostic Tests:	Yes	Yes	n/a
Deductible - see SPD for amount:	Yes	Yes	n/a
Co-insurance (% of bill paid by you after deductible):	30%	30%	n/a
Limits on Frequency of Testing:	None	None	n/a
Annual Maximum:	None	None	n/a
Doctor Office Co-payment:	No	No	n/a
Wellness Care ⁵			
Routine Immunizations:	Yes	Yes	n/a
Routine Physical Examinations:	Yes	Yes	n/a
Routine Diagnostic Tests:	Yes	Yes	n/a
Routine Gynecological Examinations:	Yes	Yes	n/a
Routine Mammograms:	Yes	Yes	n/a
Routine Colorectal Cancer Screening and Colonoscopies:	Yes	Yes ⁷	n/a
Routine Prostrate-related Testing:	Yes	Yes	n/a
Deductible – see SPD for amount:	Yes	Yes	n/a
Co-insurance (% of bill paid by you, after deductible):	30%	30%	n/a
Limits on Frequency/Type of Preventive Care Services:	Yes ⁹	Yes ^{8,9}	n/a
Annual Maximum:	None	None	n/a
Doctor Office Co-payment:	\$0	\$0	n/a

n/a – benefits not available

Footnotes

1. Unless otherwise noted, all services are subject to annual deductibles.
2. All services are subject to usual and customary charges and the deductible unless otherwise noted.
3. Not subject to annual deductible.
4. Under the prescription drug program, the member pays the applicable coinsurance and/or co-pay plus the difference between the cost of the brand and generic drug if the brand drug is selected. If physician indicates dispense as written, member does not pay the difference in cost.
5. Follow-up doctor visits and tests performed as a result of a potential health problem discovered during preventive care screenings are covered as normal medical expenses rather than as preventive care. For example, a colonoscopy performed as a result of a potential problem discovered during a routine physical would not be covered as a preventive care benefit; rather, it would be covered as a normal medical procedure.
6. All services must be approved by the Primary Care Physician (PCP). For some procedures, the PCP uses published guidelines issued by nationally recognized professional medical societies such as the National Cancer Institute.
7. One routine sigmoidoscopy or colonoscopy is covered as a preventive care benefit every 5 years.
8. All expenses are treated as normal medical expenses and are subject to the standard deductible and co-insurance. Without a diagnostic reason for performing these procedures, only one routine sigmoidoscopy or colonoscopy is covered as a preventive care benefit every 5 years.
9. Only charges for services that are reasonable and customary are eligible to be considered for reimbursement by the plan.