

Medical Plans – All Employees

Benefits	Blue Cross Blue Shield PPO Plus - P14940	Blue Cross Blue Shield HCA - P14948
Major Medical Coverage		
Treatment Facility	Personal Choice	Personal Choice
Service Area	Nationwide	Nationwide
Designation of Primary Care Physician	Not required	Not required
Specialist Referrals	Not required	Not required
Coinsurance	90% / 70%	90% / 70%
Office Visit Copay	None	None
Deductible	\$750 single / \$2,250 family	\$1,500 single / \$4,500 family
Out-of-Pocket Maximum (Deductible Included)	\$2,250 single / \$4,250 family	\$3,000 single / \$6,500 family
Health Reimbursement Account – Employer Funding	n/a	\$500 single / \$1,000 single+1 / \$1,500 family
Emergency Room Copay	\$75 (waived if admitted)	\$75 (waived if admitted)
Routine Exams, Preventive Care, and Immunizations	100%, no deductible	100%, no deductible
Chiropractic	90% / 70% after deductible	90% / 70% after deductible
Coinsurance, Hospital Care, Surgery, Maternity	With preauthorization, 90% / 70% after deductible	With preauthorization, 90% / 70% after deductible
Vision	Annual eye exam covered at 100% for all ages. Age 19 and over have \$150 allowance every 24 months for frames, lenses or contacts. Under the age of 19—one pair of glasses and one pair of contacts allowed at 100% per benefit year.	Annual eye exam covered at 100% for all ages. Age 19 and over have \$150 allowance every 24 months for frames, lenses or contacts. Under the age of 19—one pair of glasses and one pair of contacts allowed at 100% per benefit year.
Prescription Drugs (Express Scripts)		
Retail (34-day supply)	\$15 generic / \$30 formulary / \$50 non-formulary	\$15 generic / \$30 formulary / \$50 non-formulary
Mail Order (102-day supply)	\$30 generic / \$60 formulary / \$100 non-formulary	\$30 generic / \$60 formulary / \$100 non-formulary
Prescription Out-of-Pocket (Network)	\$4,900 single / \$10,050 family	\$4,150 single / \$7,800 family

Blue Cross Blue Shield Base PPO - P14946	Blue Cross Blue Shield HMO - H15078
Network Only	Network Doctor and Hospitals Only
Nationwide	IL: Cook, DuPage, Kankakee, Kendall, Kane, Lake, McHenry, Will; IN: Porter, and Lake
Not required	Required
Not required	Required
80% / N/A	100% / N/A
None	\$10 PCP / \$20 Specialist
\$500 single / \$1,200 family	n/a
\$2,500 single / \$5,200 family	Max aggregate copays for basic healthcare \$1,500 per individual / \$3,000 per family / yr.
n/a	n/a
\$75 (waived if admitted)	\$75 (waived if admitted)
100%, no deductible	100% after \$10 copay for exam
80% / 0% after deductible	100%
With preauthorization, 80% / 0% after deductible	100% / In-network only
Annual eye exam covered at 100% for all ages. Age 19 and over have \$150 allowance every 24 months for frames, lenses or contacts. Under the age of 19—one pair of glasses and one pair of contacts allowed at 100% per benefit year.	Vision discounts available
\$5 generic / \$20 formulary / \$35 non-formulary	\$15 generic / \$30 formulary / \$50 non-formulary
\$10 generic / \$40 formulary / \$70 non-formulary	\$30 generic / \$60 formulary / \$100 non-formulary
\$4,650 single / \$9,100 family	\$5,650 single / \$11,300 family



This benefit schedule is for illustrative purposes only; please consult benefits booklet for more information.

This exhibit in no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operation of the plans.

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