BlueCross BlueShield of Illinois
*Experience. Wellness. Everywhere.®*

# Community Unit School District 300

**Insurance Comparison Chart**
**Effective January 2019**

| | ***HMO Illinois*** | ***PPO PLUS*** | ***Blue Choice Select PPO*** | ***BlueEdge HSA*** |
|---|---|---|---|---|
| **Board Funded Health Savings Account (HSA)** | NA | NA | NA | Single: $750<br>&Spouse: $1500<br>&Child(ren): $1500<br>Family: $1500 |
| **Lifetime Benefit Maximum** | Unlimited | Unlimited | Unlimited | Unlimited |
| **Deductible In network / out network** | NA | **Individual**:<br>$500 (combined in and out)<br>**Family**:<br>$1500 (combined in and out) | **Individual**:<br>$500 / $1500<br>**Family**:<br>$1500 / $4500 | **Individual**:<br>$1500 combined in and out<br>**Family**:<br>$3000 combined in and out<br>Entire Family deductible must be met before expenses pay for any family member |
| **Coinsurance** | 100% | 90% In-Network<br>70% Out-of-Network | 90% In-Network<br>60% Out-of-Network | 90% In-Network<br>70% Out-of-Network |
| **Office Visit Co-Pays** | $20 | NA | NA | NA |
| **Maximum *IN-NETWORK* Out-Of-Pocket *Includes* *Deductible; Excludes* *RX copays*** | **Individual**:<br>$1500<br>**Family**:<br>$3000 | **Individual**:<br>$1100<br>**Family**:<br>$3300 | $1100 **Individual**: **Family**: $3300 | **Individual**:<br>$1750<br>**Family**:<br>$3500 |
| **Maximum *-OUT-NETWORK* Out-Of-Pocket *Includes* *Deductible; Excludes* *RX copays and balanced billed charges*** | **N/A** | **Individual**:<br>$2300<br>**Family**:<br>$6900 | **Individual**:<br>$3900<br>**Family**:<br>$11,700 | **Individual**:<br>$3750<br>**Family**:<br>$7500 |
| **Prescription Drug Co-Pays Generic/ Brand Formulary/ Non-Formulary Brand** | Retail: $15/$30/$50<br>Mail: $30/$60/$100 | Retail: $15/$30/$50<br>Mail: $30/$60/$100<br>out of network copay +25% | Retail: $15/$30/$50<br>Mail: $30/$60/$100<br>out of network copay +25% | You pay full discounted price negotiated by BCBS<br>you pay 10% after deductible<br>out of network penalty of 25% |
| **Prescription Drug Out Pocket** | $5,100 Individual<br>$10,200 Family | $5,500 Individual<br>$9,900 Family | $5,500 Individual<br>$9,900 Family | N/A |
| **Preventative Care** | 100% Covered | 100% Covered | 100% Covered | 100% Covered |
| **ER Co-Pay (Outpatient Emergency Care-excludes physician fee)** | 100% after $75 Co-Pay if covered services performed in a hospital emergency room in or out-of-network. Copay waived if admitted. | $150 Co-Pay then 10% coinsurance when covered services performed in a hospital emergency room in or out of area. Co-Pay waived if admitted | $150 Co-Pay then 10% coinsurance when covered services performed in a hospital emergency room in or out of area. Co-Pay waived if admitted | $150 Co-Pay then 10% coinsurance when covered services performed in a hospital emergency room in or out of area.<br>Co-Pay waived if admitted |

**This is just an out line of benefits. Please refer to your Summary of Benefit Coverage or certificate of coverage for details on above benefits**