

Plan Name	BCBSIL Gold G511 PPO	BCBSIL Gold G501 OPT	BCBSIL Silver S504 OPT
Network Name	Participating Provider Organization (PPO)	Participating Provider Organization (PPO) / Blue Choice Preferred PPO (BCE)	Participating Provider Organization (PPO) / Blue Choice Preferred PPO (BCE)
SUMMARY OF BENEFITS (SBC)	SBC	SBC	SBC
Individual Deductible	\$1,000.00	PPO: \$1,500.00 BCE: \$700.00	PPO: \$5,000.00 BCE: \$4,000.00
Family Deductible	2x or 3x	PPO: 2x 3x BCE: 2x or 3x	PPO: 2x or \$13,200.00 BCE: 2x or 3x
Coinsurance	80%	PPO: 70% BCE: 90%	PPO: 60% BCE: 80%
Individual Maximum Out-of-Pocket (includes deductibles/copays)	\$3,300.00	PPO: \$6,000.00 BCE: \$4,200.00	PPO: \$6,850.00 BCE: \$6,000.00
Family Maximum Out-of-Pocket	2x or 3x	PPO: 2x or \$13,200 BCE: 2x or 3x	PPO: \$13,700.00 BCE: 2x or \$13,700.00
Preventative Care (Annual Exam & Annual Physical)	NO CHARGE	NO CHARGE	NO CHARGE
Office Visit Copay (PCP/SPEC)	\$35 / \$60	PPO: \$50 / \$100 BCE: \$20 / \$40	PPO: \$50 / \$90 BCE: \$25 / \$50
Diagnostic Testing	subject to deductible	subject to deductible	subject to deductible
X-Ray and Imaging	subject to deductible	subject to deductible	subject to deductible
Prescription Drug Copay	\$0/\$10/\$50/\$100/\$150	\$0/\$10/\$35/\$75/\$150	\$0/\$10/\$35/\$75/\$150
Outpatient ER	\$400 copay + deductible	\$400 copay + deductible	\$400 copay + deductible
Outpatient Mental Health	\$35 copay	PPO: \$50 BCE: \$20	PPO: \$50 BCE: \$25
<u>Coverage Tier</u>	<u>Premiums</u>	<u>Premiums</u>	<u>Premiums</u>
Employee Only	\$455.96	\$346.04	\$296.46
Employee + Spouse	\$1,063.90	\$807.44	\$691.74
Employee + Child(ren)	\$972.71	\$738.23	\$632.44
Family	\$1,580.65	\$1,199.62	\$1,027.72