BlueCross BlueShield of Illinois

Metropolitan Water Reclamation District

Benefit Summary and Comparison for Non-Medicare Retired Employees
For complete coverage details, please refer to your plan documents or call Customer Service.

January 1, 2018, to December 31, 2018

bcbsil.com/mwrd

SCHEDULE OF BENEFITS

	HMO Illinois® (H31914-100)	PPO (P31914)	
		In-Network	Out-of-Network
DEDUCTIBLE			
Individual	$0	$350	$350
Employee/dependent	$0	$700	$700
Family deductible	$0	$1,050	$1,050
Hospital deductible per admission	$0	N/A	$150
OUT-OF-POCKET EXPENSE			
Individual out-of-pocket expense	$1,500	$1,500	$3,000
Family out-of-pocket expense	$3,000	$4,000	$9,000
OUTPATIENT PHYSICIAN			
Office visits	$25 copay*	85%	70% of U&C**
Diagnostic testing (i.e., X-ray, lab, etc.)	Covered in full	85%	80% of U&C
Outpatient surgeon	Covered in full	85%	70% of U&C
Routine physical checkups (adult)	Covered in full	Covered under Preventive Services Benefits	
Routine pediatric checkups, well baby care and pre-school exams	Covered in full	Covered under Preventive Services Benefits	
Immunizations	Covered in full	Covered under Preventive Services Benefits	
Allergy shots	Covered in full	85%	70% of U&C
Hearing screenings	Covered in full	Covered under Preventive Services Benefits	
Physical therapy, occupational therapy and speech therapy	Sixty (60) combined visits – per calendar year	85%	70% of U&C
Podiatry care (routine foot care and prescriptions for supportive foot devices are not covered)	Covered in full	85%	70% of U&C
Cosmetic surgery (medically necessary restorative surgery)	Covered in full	85%	70% of U&C
Oral surgery (services for dental care are not covered unless required due to surgical removal of a tumor, in connection with an injury, or by treatment of malerupted bony impacted wisdom teeth)	$25 copay per admission*	Limited services covered at 85%	Limited services covered at 70% of U&C
HOSPITAL			
Room and board (private room is covered in full if medically necessary)	Covered in full	85%	80% $150 copay
Number of days	Unlimited	Unlimited, subject to medical necessity	
Intensive care and other special units	Covered in full	85%	80% of U&C

Inpatient surgery	Covered in full	85%	80% of U&C
Outpatient surgery	$25 copay per admission*	85%	70% of U&C
Skilled nursing facility	Covered in full, up to 120 days per calendar year	85%	80% of U&C
Physican visits	Covered in full	85%	70% of U&C
Specialist visits	Covered in full	85%	70% of U&C
Anesthesiologist	Covered in full	85%	70% of U&C
Surgery	$25 copay per admission*	85%	70% of U&C
MATERNITY			
Physician	$25 copay* for 1st visit only	85%	70% of U&C
Hospital/delivery	Covered in full	85%	80% of U&C
Waiting period	None	None	None
MENTAL HEALTH/CHEMICAL DEPENDENCY			
Outpatient visits – mental health	$25 copay per office visit*	85%	70% of U&C
Inpatient care – mental health	Covered in full	85%	80% of U&C
Outpatient visits – chemical dependency	$25 copay per office visit*	85%	70% of U&C
Inpatient care – chemical dependency	Covered in full	85%	80% of U&C
EMERGENCY CARE			
If you as a prudent layperson (with an average knowledge of health and medicine) ever need to go to the hospital emergency room, the services will be covered. In these situations, go directly to the nearest hospital emergency room.	$100 emergency room copay. If you are admitted from the emergency room, the $100 copay is waived. However, we do recommend you call your doctor for treatment advice in any medical emergency.	85%	85% of U&C
		$100 copay waived if admitted	
Ambulance	Covered in full	85%	85% of U&C
Prosthetic devices and durable medical equipment (DME)	Covered in full	85%	70% of U&C
Blood	Covered in full	85%	80% of U&C
Infertility treatment	$25 copay*	Not covered	
Home health services – hospital	Covered in full	85%	80%
Home health services – outpatient	Covered in full	85%	70%
Vision services	$25 copay* Call **844-684-2254**; annual exam covered in full; discounts available at participating locations.	Not covered	

SCHEDULE OF BENEFITS

	HMO Illinois (H31914-100)	PPO (P31914)	
		In-Network	Out-of-Network
PREVENTIVE SERVICES BENEFITS			
• Immunizations – see plan documents for specifics • Routine bone density test • Routine breast exam • Routine colonscopy • Routine colorectal cancer screening • Routine digital rectal exam • Routine gynecological exam • Routine lab procedures • Routine mammogram • Routine pap test • Routine physical • Smoking cessation • Screening – lab • Visual acuity • Well baby care Cancer Screenings: • Breast cancer screening (mammography) for women over the age of 40 • Cervical cancer screening (pap test) for women • Colorectal cancer screenings using fecal occult blood testing, sigmoidoscopy or colonoscopy for adults from age 50 to 75 • Prostate cancer (PSA) screening for men	Covered in full	Preventive services listed are covered at 100% of allowed amount	

BENEFITS OUTSIDE THE SERVICE AREA

HMO Illinois (H31914-100)

Urgent care is covered while traveling out of state for unexpected illness and injury. When medical services are needed away from home, call the toll-free number located on the back of your member identification card and we will quickly put you in touch with an away from home coordinator near your location. The coordinator will schedule your appointment and give you directions. Guest Membership is provided at an affiliated HMO if you or a covered dependent travels away from the service area for at least 90 days. Whether the reason is extended out-of-town business, semesters at school or families living apart, you can still enjoy the full range of benefits offered by the affiliated HMO near your travel destination.

PPO (P31914)

In-Network: **85%**	Out-of-Network: **70%**

HMO Illinois Customer Service:	PPO Customer Service:
800-892-2803	**800-772-6895**
Monday through Friday, 7 a.m. to 6 p.m.	Monday through Friday, 7 a.m. to 6 p.m.

PRESCRIPTIONS – HMO Illinois (H31914-100) and PPO (P31914)

	Network Pharmacy	Out-of-Network Pharmacy
Retail – 30-day supply (short-term medication)	**100% after:** $9 Generic drugs copay $25 Preferred brand drugs copay $45 Non-preferred brand drugs copay $100 Specialty drugs copay	**75% after:** $9 Generic drugs copay $25 Preferred brand drugs copay $45 Non-preferred brand drugs copay $100 Specialty drugs copay
Mail Order – 90-day supply (long-term medication)	**100% after:** $18 Generic drugs copay $50 Preferred brand drugs copay $90 Non-preferred brand drugs copay	**75% after:** $18 Generic drugs copay $50 Preferred brand drugs copay $90 Non-preferred brand drugs copay