Benefits Summary & Rates
Effective 9/1/2023-8/31/2024

Major Medical Insurance: Blue Cross Blue Shield (BCBS)

Health Maintenance Organization (HMO) – When selecting an HMO, you will need to choose and register with your current carrier a Primary Care Physician (PCP) from a list of network providers. If you require a specialist, outpatient procedure, or hospitalization, your registered PCP must refer you. This ensures you remain within your HMO network. There are no out-of-network benefits with an HMO. **REMINDER: Select your PCP & submit the Medical Group/IPA to Dana Holman Ph: (708) 367-8334 or holmand@cm201u.org.**

Preferred Provider Organization (PPO) – Although you have the flexibility to see any doctor or visit any hospital of your choice, you will pay significantly less money out of your pocket if you use a doctor or hospital that is in the network. For most doctor visits and preventative care visits, you simply pay a copayment at the time of service. You have a great deal of flexibility and choice with a PPO, and can manage your out-of-pocket costs by remaining in network. **Utilizing the Blue Choice Options Network will provide a higher level of benefits.**

In-Network Benefits	HMO (Blue Advantage)	PPO *(Big Network)*	PPO *(Small Network-Blue Choice Options)*
Deductible (January – December) *Individual / Family*	**$250/$500**	**$2500 / $5,000**	**$1250 / $2500**
Coinsurance	100%	**70%**	**90%**
Out-of-Pocket Max (Includes Deductible) *Individual / Family*	**$3,000 / $6,000**	**$5,000 / $10,000**	**$2500 /$5,000**
Physician Services *Preventive Care* *Physician / Specialist Office Visit*	100% **$25/$50 Copay**	**100%** **$30/$50 Copay**	**100%** **$20/$40 Copay**
Inpatient Hospital Deductible	**$300 waived if admitted**	**Deductible / 70%**	**Deductible / 90%**
Emergency Room	**100%**	**$300 waived if admitted**	**$300 waived if admitted**
Prescription Drugs *Tier 1 / Tier 2 / Tier 3 Preferred Network*	$15/$30/$50/$50	**$15/$80/$120/N/A**	**$15/$40/$60/$120**
Prescription Drug Out-of-Pocket Max	$1,000 Single $2,000 Family	**$1500 Single** **$3,000 Family**	**$1500 Single** **$3,000 Family**
Per Paycheck Deductions (26 pays)			
Employee Only	**$0.00**	**$70.44**	
Employee + 1	**$242.84**	**$356.60**	
Family	**$364.45**	**$499.91**	

Telemedicine: 1.800MD – CONVENIENT CARE ANYWHERE 24/7/365

- You & your family have access to board certified physicians via telephone or secure video that can advise, diagnose or treat illness, and even prescribe medication right over the phone. **No co-pay or deductible.**
- Common treated conditions include: allergies, cold & flu, laryngitis, skin infections, ear infections, pink eye, insect bites, minor burns, sinusitis, sprains & strains, urinary tract infections as well as other non-emergent issues.
- Activate your account online at www.1800md.com or by calling member services at (800) 530-8666.

Dental Insurance: Blue Cross Blue Shield (BCBS)

Choice of plan options	PPO In-Network / Out-of-Network
Deductible *Individual* *Family* (Waived for Preventive)	 $25 / $50 $50 / $100
Preventive Coinsurance	100% / 100%
Basic Coinsurance	90% / 80%
Major Coinsurance	60% / 50%
Annual Plan Maximum	$2,000 / $2,000
Orthodontia Coinsurance	50% / 50%
Orthodontia Lifetime Max	$1,500 / $1,000
Posterior Composites	Basic-90%
Per Paycheck Deductions	**26 pays**
Employee Only	**$0.00**
Employee + 1	**$15.51**
Family	**$37.35**

CLAIMS CONCIERGE SERVICE

This service is no longer offered. If you have plan/billing issues,

please contact Mrs. Dana Holman, Benefits Coordinator for assistance, I will work with our new broker to assist you.

Voluntary Vision Care: Blue Cross Blue Shield

Benefits	In Network
Eye Exam	$10 Co-Pay
Standard Lenses *Single* *Bifocal* *Trifocal* Standard Progressives	 $25 Co-Pay $25 Co-Pay $25 Co-Pay $90 Co-Pay
Frames	$130 Allowance; 20% off balance over $130
Contacts *Conventional* *Disposable* *Medically Necessary*	 $130 Allowance; 15% off balance over $130 $130 Allowance Paid in Full
Frequency Eye Exam Lenses or Contacts Frames	 Once Every 12 Months Once Every 12 Months Once Every 24 Months
Per Paycheck Deductions	26 pays
Employee Only	**$3.51**
Employee + Spouse/1	**$6.66**
Employee +Child(ren)	**$7.02**
Family	**$10.32**

Voluntary Accident & Critical Illness Blue Cross Blue Shield

Choice of plan options	Voluntary Accident Options
Ambulance Blood/Plasma Bruns Coma	$200 GROUND: $1500 AIR $200 Schedule up to $12,500 $12,500
Concussion Dental Work Diagnostic Testing Dislocation	$150 Specific sum $130-$400 $200 Schedule up to $4,000
ER Treatment	$150
Eye Injury Family Lodging	$300 $125
Follow-Up Treatments	$50
Fracture Hospital Admission Hospital Confinement ICU Confinement	Schedule up to $5,000 $1,200 $250 $500
Laceration	Schedule up to $500
Medical Appliance Paralysis Physical Therapy Prosthesis Rehabilitation Surgery Transportation	$125 $12,500 quad, $6,250 Para $35 One$750: Two + $1500 $150 Schedule up to $1250 $600
Urgent Care Center	$150
X-Ray	$50
Accident Death	EE $40,000 Sps $40,000 Child $12,500
Accident Death Common Carrier	EE $150,000 Sps $150,000 Child $25,000
Wellness Benefit	$50 per year per insured
ADDITIIONAL PROVISION	
24-HOUR/Off Job	
Benefit Reductions Portable Courage Pre-Existing Condition Limitation	Terms at retirement or age 70 12 months and under 60 to port. Port terms at age 65 No
PLAN COST/MONTHLY PREMIUMS	
EMPLOYEE	$11.22
EMPLOYEE + SPOUSE	$18.56
EMPLOYEE + CHILDREN	$21.65
FAMILY	$33.95

Please contact Mrs. Dana Holman, Benefits Coordinator for questions pertaining to coverage options

Mrs. Dana Holman, Benefits Coordinator
708-367-8334
FAX 708-367-6895

Choice of plan options	Voluntary Critical Illness
Benefit Amounts	
Employee	$5,000 increments up to $50,000
Spouse	$2500 increments up to $25000 not to exceed 50% of EE Election
Child	$2500 increments up to $25,000 not to exceed 50% of EE Election
Guarantee Issue Perpetual GI	$20,000, EE $10,000 SP, $10000 CH Yes
Benefit Type	
Benign Brain Tumor	100%
Burn	100%
Cancer Invasive	100%
Carcinoma in Situ	25%
Coma	100%
Covid-19 Severe Infection	100%
End Stage Renal Failure	100
Heart Attack	100%
Loss of Sight	100%
Loss of Hearing	100%
Loss of Speech	100%
Major Heart Surgery	25%
Major Organ Transplant	100%
Paralysis	100%
Stroke	100%
Wellness Benefit	$50 per year per insured
Provisions	
Reoccurrence	50% of the following covered conditions: Cancer, Heart Attack, Stroke, Benign Brain Tumor, Coma. 180 Days for the separation Period.
Limitations	
Benefit Reduction	35% Age 65 50% age 70 Terms at Retirement
Portable Coverage	Yes, at Group Rates
Pre-existing condition limitations	12/12
Plan costs are monthly per $1,000 based on age	
EE Age Band	Spouse
Below 30 $0.395	Below 30 $0.608
30-39 $0.588	30-39 $0.816
40-49 $1.100	40-49 $1.344
50-59 $2.030	50-59 $2.286
60-64 $3.242	60-64 $3.503
65+ $4.566	65+ $4.994
Child $0.201	