



# Mokena School District #159

Insurance Committee Meeting

July 1, 2025 Renewal Date

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April 24, 2025

Presented by:

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Producer  
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## Mokena School District #159

A Renewal Analysis  
July 1, 2025 Renewal Date

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### MTA & MCSA Summary of Current Coverages- Mokena School District #159

The coverages renewing on July 1, 2025 are checked.

Coverage	Carrier / A.M. Best Rating	Policy Number(s)	Renewal Date
✓ Medical	Blue Cross Blue Shield of Illinois / A+	PPO500- P49362 HSA- 347995 PPOBCS500- OMD424 BAHMO- B47111	7/1/2025 <i>Revised- 15.9% Increase</i> <i>Original- 20.70% Increase</i>
Dental	Cigna / A	3343668	7/1/2026
✓ Voluntary Vision	Vision Service Plan / A	30026853	7/1/2025 <i>Revised- 4% Increase w/2- Year Rate guarantee</i> <i>Original- 7% Increase</i>
✓ Voluntary Life/Ad&d	Guardian / A++	00022266	7/1/2025 <i>No Increase</i>
✓ Worksite Accident, Critical Illness & Hospital Indemnity	Guardian / A++	00022266	7/1/2025 <i>(Individual Pricing- No Increase)</i>
✓ Worksite Pet Insurance	Pet Partners / A-	Mokena	7/1/2025 <i>(New Pricing is based on pet's age, breed and zip code)</i>

## Mokena School District #159

A Renewal Analysis

July 1, 2025 Renewal Date

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### Markets Approached

#### MEDICAL

Current Carrier / A.M. Best Rating	Status	Disposition
BCBS of Illinois / A+	Renewal Received	Revised Renewal Increase: <i>Revised- +15.9% Increase</i>  Original Renewal Increase: <i>+20.70% renewal increase</i>
Alternate Carriers / A.M. Best Rating		
Cigna / A	Quote Received	+14.4% higher than the current rates
United Healthcare / A+	Quote Received	+13.3% higher than the current rates

### Large Claim Range and Detail

Reflects Claimants with over \$25,000 in Incurred Claims Provided at Renewal  
12/1/2019 - 11/30/24

	12/1/17-11/30/18 * (7/1/2019 Renewal) *	12/1/18-11/30/19 (7/1/2020 Renewal)	12/1/19-11/30/20 (7/1/2021 Renewal)	12/1/20-11/30/21 (7/1/2022 Renewal)	12/1/21-11/30/22 (7/1/2023 Renewal)	12/1/22-11/30/23 (7/1/2024 Renewal)	12/1/23-11/30/24 (7/1/2025 Renewal)
Number of Claimants \$25,001 - \$50,000	2 \$27,643 Active \$29,940 Active	1 \$49,578 Active	0	0	0	0	0
Total Paid Claims	\$57,583	\$49,578	\$0	\$0	\$0	\$0	\$0
Number of Claimants \$50,001 - \$70,000	4 \$59,496 Active \$64,309 Active \$68,078 Active \$69,312 Active	3 \$51,865 Active \$54,711 Active \$66,988 Active	2 \$61,148 Active \$64,708 Active	2 \$57,954 Cancelled \$66,494 Active	2 \$54,906 Active \$58,609 Active	7 \$54,042 Active \$55,772 Cancelled \$55,830 Active \$56,019 Cancelled \$56,142 Active \$61,903 Active \$63,543 Active	3 \$62,999 Active \$63,464 Active \$69,287 Cancelled
Total Paid Claims	\$261,195	\$173,564	\$125,856	\$124,448	\$113,515	\$403,251	\$195,750
Number of Claimants \$70,001 - \$100,000	4 \$74,758 Active \$85,961 Active \$90,069 Active \$94,090 Active	2 \$71,651 Active \$91,279 Active	3 \$70,229 Active \$86,494 Active \$88,508 Active	3 \$70,830 Active \$88,090 Active \$90,108 Active	4 \$73,961 Active \$76,588 Active \$91,220 Active \$92,150 Active	1 \$79,315 Active	1 \$89,470 Active
Total Paid Claims	\$344,878	\$162,930	\$269,485	\$273,282	\$333,919	\$79,315	\$89,470
Number of Claimants \$100,001 & Over	1 \$116,281 Active	0	1 \$100,216 Active	1 \$633,926 Active	1 \$733,325 Active	4 \$112,253 Active \$161,794 Active \$168,375 Active \$542,448 Active	8 \$117,273 Active \$121,535 Active \$123,480 Active \$155,693 Active \$163,734 Active \$176,408 Active \$280,347 Active \$436,237 Active
Total Paid Claims	\$116,281	\$0	\$100,216	\$633,926	\$733,325	\$984,870	\$1,574,707
Total Claimants with claims in Excess of \$25,000 - #/\$	11 / \$779,937	6 / \$386,072	6 / \$495,557	6 / \$1,031,656	7 / \$1,180,759	12 / \$1,467,436	12 / \$1,859,927

Please note: The member's status (active/terminated) is as of the date the renewal was released.

**Blue Cross Blue Shield of Illinois (BCBSIL)**  
**Medical Renewal Evaluation Summary**  
**(7/1/19 - 6/30/26)**

Health Renewal Premium Change Components	7/1/19-6/30/20	7/1/20-6/30/21	7/1/21-6/30/22	7/1/22-6/30/23*	7/1/23-6/30/24	7/1/24-6/30/25	7/1/25-6/30/26
a. Account/Benefit Program Adjustment (including Trend)	+3.07%	+10.56%	+4.29%	+3.34%	+7.01%	+4.55%	+9.10%
b. Demographic Adjustment	+0.06%	+1.61%	+0.44%	+0.56%	-1.90%	+1.24%	-0.70%
c. Change in Risk:	+2.84%	-6.54%	-1.13%	+12.21%	+6.87%	+10.03%	+11.50%
<b>Initial Renewal Increase:</b>	<b>+5.97%</b>	<b>+5.63%</b>	<b>+3.60%</b>	<b>+16.65%</b>	<b>+12.24%</b>	<b>+16.51%</b>	<b>+20.70%</b>
<b>Final Negotiated Renewal Increase:</b>	<b>+3.10%</b>	<b>+0.00%</b>	<b>+0.01%</b>	<b>+8.91%</b>	<b>+7.92%</b>	<b>+9.86%</b>	<b>+15.90%</b>
<b>Final Negotiated Renewal Increase with Plan Changes (if any):</b>	<b>+3.10%</b>	<b>+0.00%</b>	<b>+0.01%</b>	<b>+7.22%</b>	<b>+7.92%*</b>	<b>+9.86%</b>	<b>Pending</b>

\* Mokena eliminated the \$1,000 PPO and Value Choice HMO eff. 7/1/23.

#### Change Component Definitions

- a) Account/Benefit Program Adjustment (incl. Trend) includes group and benefit plan specific pricing changes due to factors such as medical cost trends, pool adjustments, plan, industry and geographical pricing, etc.
- b) Demographic Adjustment is the pricing change for age, gender, group size and dependent composition differences.
- c) Change in Risk is the pricing change resulting from BCBSIL's analysis of medical conditions and experience.

\* The initial renewal increase is calculated by multiplying each of the components in the above table. The percentage of the rate change varies by enrollment tier (ee, ee/ch, ee/sp or f) and plan (HMO, PPO and HSA). The negotiated renewal increase is based on enrollment via Mokena's provided census.

Mokena School District #159

Renewal Medical Financial Analysis (MTA & MCSA Members)

(Including Employee Contributions)

July 1, 2025 Renewal Date

	Blue Cross Blue Shield IL (7/1/24-6/30/25) Current Policy Year Original Renewal- 16.57% Revised Renewal- 9.92%		Blue Cross Blue Shield IL (7/1/25-6/30/26) Renewal Policy Year Original Renewal- 20.7% Revised Renewal- 15.9%	
	3/25		3/25	
	Census Enrollment		Census Enrollment	
Billed Premium				
PPO (\$500 Deductible)		MPP73436		MPP73436
Employee	71	\$1,063.37	71	\$1,294.53 (+21.7%)
Employee + Spouse	1	\$2,272.12	1	\$2,572.78 (+13.2%)
Employee + Child(ren)	11	\$2,108.98	11	\$2,484.63 (+17.8%)
Family	0	\$3,317.72	0	\$3,762.89 (+13.4%)
Est. Monthly Premium		\$100,970.17		\$121,815.34
Est. Annual Premium	83	\$1,211,642.04	83	\$1,461,784.08
Est. Annual Increase (\$)				\$250,142.04
Est. Annual Increase (%)				(+20.6%)
HSA Plan (Options PPO)		HSA Plan MICOE4064		HSA Plan MICOE4064 Changing to MICOE4065- Eliminate Plan
Employee	0	\$796.73	0	\$937.80 (+17.7%)
Employee + Spouse	0	\$1,702.36	0	\$1,863.80 (+9.5%)
Employee + Child(ren)	0	\$1,580.14	0	\$1,799.94 (+13.9%)
Family	0	\$2,485.77	0	\$2,725.94 (+9.7%)
Est. Monthly Premium		\$0.00		\$0.00
Est. Annual Premium	0	\$0.00	0	\$0.00
Est. Annual Increase (\$)				\$0.00
Est. Annual Increase (%)				(N/C)
Blue Choice Select PPO		MIBCS2030		MIBCS2030 Changing to MIBCS2035
Employee	11	\$885.42	11	\$1,043.40 (+17.8%)
Employee + Spouse	1	\$1,891.85	1	\$2,073.69 (+9.6%)
Employee + Child(ren)	6	\$1,756.03	6	\$2,002.63 (+14.0%)
Family	5	\$2,762.48	5	\$3,032.92 (+9.8%)
Est. Monthly Premium		\$35,980.05		\$40,731.47
Est. Annual Premium	23	\$431,760.60	23	\$488,777.64
Est. Annual Increase (\$)				\$57,017.04
Est. Annual Increase (%)				(+13.2%)
HMO (BAHMO)		NHHB103		NHHB103
Employee	18	\$827.23	18	\$948.49 (+14.7%)
Employee + Spouse	3	\$1,767.55	3	\$1,885.04 (+6.6%)
Employee + Child(ren)	10	\$1,640.64	10	\$1,820.46 (+11.0%)
Family	5	\$2,580.95	5	\$2,757.03 (+6.8%)
Est. Monthly Premium		\$49,503.94		\$54,717.69
Est. Annual Premium	36	\$594,047.28	36	\$656,612.28
Est. Annual Increase (\$)				\$62,565.00
Est. Annual Increase (%)				(+10.5%)
Est. Combined Monthly Premium		\$186,454.16		\$217,264.50
Est. Combined Annual Premium	142	\$2,237,449.92	142	\$2,607,174.00
Est. Renewal Increase				\$369,686.14 (+16.5%)
Est. Annual ACA Tax/Fee Increase				\$37.94 (+0.00%)
Est. Gross Annual Premium Increase				\$369,724.08 (+16.5%)
Affordable Care Act Taxes/Fees		ACA Taxes/Fees are Included in Rates Above		
Patient Centered Outcome Research Institute (PCORI) Fee/Tax		\$902.43		\$940.37
(Based on 271 estimated covered members)		Est. \$3.33 per covered member		Est. \$3.47 per covered member
Health Insurance Industry Fee/Tax		\$0.00		\$0.00
		(Repealed in 2021)		(Repealed in 2021)
Est. ACA Cost		\$902.43		\$940.37
Est. Annual Fee Increase (\$)				\$37.94



Mokena School District #159

Renewal Medical Financial Analysis (MTA & MCSA Members)

(Including Employee Contributions)

July 1, 2025 Renewal Date

		Blue Cross Blue Shield IL (7/1/24-6/30/25) Current Policy Year Original Renewal- 16.57%		Blue Cross Blue Shield IL (7/1/25-6/30/26) Renewal Policy Year Original Renewal- 20.7%	
Employee Contributions					
PPO Plan (\$500 Deductible)					
		Certified		Certified	
Employee	49	\$0.00 (N/C)	49	\$2.00 (0.2%)	
Employee + Spouse	1	\$916.40 (40.3%)	1	\$1,066.73 (41.5%)	
Employee + Child(ren)	10	\$696.71 (33.0%)	10	\$884.53 (35.6%)	
Family	0	\$1,766.08 (53.2%)	0	\$1,988.66 (52.8%)	
Est. Monthly Employee Contributions		\$7,883.50		\$10,010.03	
Est. Annual Employee Contributions		60 \$94,602.00 (7.8%)		60 \$120,120.36 (8.2%)	
		Classified (9 months)		Classified (9 months)	
Employee	14	\$0.00 (N/C)	14	\$2.00 (0.2%)	
Employee + Spouse	0	\$916.40 (40.3%)	0	\$1,066.73 (41.5%)	
Employee + Child(ren)	0	\$696.71 (33.0%)	0	\$884.53 (35.6%)	
Family	0	\$1,766.08 (53.2%)	0	\$1,988.66 (52.8%)	
Est. Monthly Employee Contributions		\$0.00		\$28.00	
Est. Annual Employee Contributions		14 \$0.00 (N/C)		14 \$336.00 (0.0%)	
		Classified (10 months)		Classified (10 months)	
Employee	2	\$0.00 (N/C)	2	\$2.00 (0.2%)	
Employee + Spouse	0	\$916.40 (40.3%)	0	\$1,066.73 (41.5%)	
Employee + Child(ren)	0	\$696.71 (33.0%)	0	\$884.53 (35.6%)	
Family	0	\$1,766.08 (53.2%)	0	\$1,988.66 (52.8%)	
Est. Monthly Employee Contributions		\$0.00		\$4.00	
Est. Annual Employee Contributions		2 \$0.00 (N/C)		2 \$48.00 (0.0%)	
		Classified (12 months)		Classified (12 months)	
Employee	6	\$0.00 (N/C)	6	\$2.00 (0.2%)	
Employee + Spouse	0	\$916.40 (40.3%)	0	\$1,066.73 (41.5%)	
Employee + Child(ren)	1	\$696.71 (33.0%)	1	\$884.53 (35.6%)	
Family	0	\$1,766.08 (53.2%)	0	\$1,988.66 (52.8%)	
Est. Monthly Employee Contributions		\$696.71		\$896.53	
Est. Annual Employee Contributions		7 \$8,360.52 (0.7%)		7 \$10,758.36 (0.7%)	
Est. Combined Monthly Employee Contributions		\$8,580.21		\$10,938.56	
Est. Combined Annual Employee Contributions		83 \$102,962.52 (8.5%)		83 \$131,262.72 (9.0%)	
Blue Choice Select PPO					
		Certified		Certified	
Employee	8	\$0.00 (N/C)	8	\$0.00 (N/C)	
Employee + Spouse	1	\$657.41 (34.7%)	1	\$748.33 (36.1%)	
Employee + Child(ren)	5	\$482.22 (27.5%)	5	\$605.52 (30.2%)	
Family	3	\$1,372.94 (49.7%)	3	\$1,508.16 (49.7%)	
Est. Monthly Employee Contributions		\$7,187.33		\$8,300.41	
Est. Annual Employee Contributions		17 \$86,247.96 (20.0%)		17 \$99,604.92 (20.4%)	
		Classified (9 months)		Classified (9 months)	
Employee	0	\$0.00 (N/C)	0	\$0.00 (N/C)	
Employee + Spouse	0	\$657.41 (34.7%)	0	\$748.33 (36.1%)	
Employee + Child(ren)	0	\$482.22 (27.5%)	0	\$605.52 (30.2%)	
Family	1	\$1,372.94 (49.7%)	1	\$1,508.16 (49.7%)	
Est. Monthly Employee Contributions		\$1,372.94		\$1,508.16	
Est. Annual Employee Contributions		1 \$16,475.28 (3.8%)		1 \$18,097.92 (3.7%)	
		Classified (10 months)		Classified (10 months)	
Employee	1	\$0.00 (N/C)	1	\$0.00 (N/C)	
Employee + Spouse	0	\$657.41 (34.7%)	0	\$748.33 (36.1%)	
Employee + Child(ren)	0	\$482.22 (27.5%)	0	\$605.52 (30.2%)	
Family	0	\$1,372.94 (49.7%)	0	\$1,508.16 (49.7%)	
Est. Monthly Employee Contributions		\$0.00		\$0.00	
Est. Annual Employee Contributions		1 \$0.00 (N/C)		1 \$0.00 (N/C)	
		Classified (12 months)		Classified (12 months)	
Employee	2	\$0.00 (N/C)	2	\$0.00 (N/C)	
Employee + Spouse	0	\$657.41 (34.7%)	0	\$748.33 (36.1%)	
Employee + Child(ren)	1	\$482.22 (27.5%)	1	\$605.52 (30.2%)	
Family	1	\$1,372.94 (49.7%)	1	\$1,508.16 (49.7%)	
Est. Monthly Employee Contributions		\$1,855.16		\$2,113.68	
Est. Annual Employee Contributions		4 \$22,261.92 (5.2%)		4 \$25,364.16 (5.2%)	
Est. Combined Monthly Employee Contributions		\$10,415.43		\$11,922.25	
Est. Combined Annual Employee Contributions		23 \$124,985.16 (28.9%)		23 \$143,067.00 (29.3%)	

Mokena School District #159

Renewal Medical Financial Analysis (MTA & MCSA Members)

(Including Employee Contributions)

July 1, 2025 Renewal Date

Blue Cross Blue Shield IL (7/1/24-6/30/25) Current Policy Year Original Renewal- 16.57%			Blue Cross Blue Shield IL (7/1/25-6/30/26) Renewal Policy Year Original Renewal- 20.7%		
HMO Plan (BAHMO)					
Certified			Certified		
Employee	7	\$0.00 (N/C)	7	\$0.00 (N/C)	
Employee + Spouse	2	\$461.26 (26.1%)	2	\$508.05 (27.0%)	
Employee + Child(ren)	10	\$317.74 (19.4%)	10	\$407.65 (22.4%)	
Family	4	\$1,128.77 (43.7%)	4	\$1,201.61 (43.6%)	
Est. Monthly Employee Contributions		\$8,615.00		\$9,899.04	
Est. Annual Employee Contributions	23	\$103,380.00 (17.4%)	23	\$118,788.48 (18.1%)	
Classified (9 months)			Classified (9 months)		
Employee	7	\$0.00 (N/C)	7	\$0.00 (N/C)	
Employee + Spouse	1	\$461.26 (26.1%)	1	\$508.05 (27.0%)	
Employee + Child(ren)	0	\$317.74 (19.4%)	0	\$407.65 (22.4%)	
Family	0	\$1,128.77 (43.7%)	0	\$1,201.61 (43.6%)	
Est. Monthly Employee Contributions		\$461.26		\$508.05	
Est. Annual Employee Contributions	8	\$5,535.12 (0.9%)	8	\$6,096.60 (0.9%)	
Classified (10 months)			Classified (10 months)		
Employee	1	\$0.00 (N/C)	1	\$0.00 (N/C)	
Employee + Spouse	0	\$461.26 (26.1%)	0	\$508.05 (27.0%)	
Employee + Child(ren)	0	\$317.74 (19.4%)	0	\$407.65 (22.4%)	
Family	0	\$1,128.77 (43.7%)	0	\$1,201.61 (43.6%)	
Est. Monthly Employee Contributions		\$0.00		\$0.00	
Est. Annual Employee Contributions	1	\$0.00 (N/C)	1	\$0.00 (N/C)	
Classified (12 months)			Classified (12 months)		
Employee	3	\$0.00 (N/C)	3	\$0.00 (N/C)	
Employee + Spouse	0	\$461.26 (26.1%)	0	\$508.05 (27.0%)	
Employee + Child(ren)	0	\$317.74 (19.4%)	0	\$407.65 (22.4%)	
Family	1	\$1,128.77 (43.7%)	1	\$1,201.61 (43.6%)	
Est. Monthly Employee Contributions		\$1,128.77		\$1,201.61	
Est. Annual Employee Contributions	4	\$13,545.24 (2.3%)	4	\$14,419.32 (2.2%)	
Est. Combined Monthly Employee Contributions		\$10,205.03		\$11,608.70	
Est. Combined Annual Employee Contributions	36	\$122,460.36 (20.6%)	36	\$139,304.40 (21.2%)	
Est. Combined Monthly Employee Contributions		\$29,200.67		\$34,469.51	
Est. Combined Annual Employee Contributions	142	\$350,408.04 (15.7%)	142	\$413,634.12 (15.9%)	
Estimated Annual Cost to Mokena School District #159		\$1,887,041.88			\$2,193,539.88
Est. Annual Increase (\$)					\$306,498.00
Est. Annual Increase (%)					(+16.2%)





# Network Offerings Comparison

Plan Name	BluePrint PPO	Blue Choice Select PPO	Blue Choice Options PPO	Blue Advantage HMO
Network Name	PPO (PPO)	Blue Choice PPO (BCS)	Tier 1 - Blue Choice OPT PPO (BCO) Tier 2 - PPO (PPO)	Blue Advantage HMO (ADV)
Network Type	Broad	Narrow	Tiered	Broad
Coverage	Statewide	Coverage area is Statewide except Lawrence and Wabash	Tier 1 - Statewide Tier 2 - Statewide	Cook, Lake, McHenry, DuPage, Kane, Grundy, Kankakee, Kendall, Will, Boone, DeKalb, Lee, Ogle, Stephenson, Winnebago, Fulton, Knox, Marshall, Peoria, Stark, Tazewell, Woodford, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Sangamon, and Schuyler counties
Must Live in Network Service Area	No	Yes	No	Yes
Medical Group Selection Required	No	No	No	Yes
Referral Required	No	No	No	Yes
OON Coverage	Yes, but member is not held harmless. The member can be billed up to the billed amount.	Yes, but member is not held harmless. The member can be billed up to the billed amount.	Yes, but member is not held harmless. The member can be billed up to the billed amount.	No with the exception of emergency or accident
BlueCard®/Away From Home Care® (AFHC)	Yes	Yes	Yes - Paid at Tier 1	Available for when members need emergency or urgent care services while outside their service areas, the BlueCard program will help them locate participating doctors and hospitals, allowing them to receive covered care.
Guest Membership	N/A	N/A	N/A	Guest Membership enables members to receive guest membership benefits from other participating Blue Cross and Blue Shield HMOs while traveling outside of their HMO service areas for at least 90 days. Affiliated HMOs are not available in all locations, and not all Blue Cross and Blue Shield Association HMOs participate in the Guest Membership program. Benefits and the way members access services might not be the same as their Illinois benefits. To apply for the Guest Membership program, members must contact Customer Service at 1-800-892-2803.
Blue Access for Members	Yes	Yes	Yes	Yes
Provider Finder®	Yes	Yes	Yes	Yes, displays PCP and Medical Group only for IL HMOs
Member Liability Estimator	Yes	Yes	Yes	No

# Blue Choice Options

## Understanding and Using the Benefits

With a PPO benefit plan, visiting doctors and hospitals in the PPO network saves money. But did you know that with the Blue Choice Options benefit plan, members can save even more money by using a doctor or hospital that participates in the Blue Choice OPT PPO network?

### What Is a Blue Choice Options Plan?

The Blue Choice Options benefit plan is designed in three tiers. Members **save** the most when they use doctors and hospitals in tier 1 – the Blue Choice Options PPO network. Members **pay** the most when they visit those in tier 3 (out-of-network providers). Remember to determine which tier the doctor or hospital is in to know the coverage level.

### Why Using a Blue Choice Options PPO Network Provider Saves Money

The Blue Choice OPT PPO network (tier 1) has a variety of doctors and hospitals statewide. These doctors and hospitals, which all meet BCBSIL’s quality criteria, have agreed to offer the care and services needed for a lower cost. In addition, with the Blue Choice Options benefit plan, members also get the highest level of benefits when visiting the doctors and hospitals in the Blue Choice OPT PPO network. Members still have the option of choosing a doctor from the larger, statewide PPO network (tier 2), but will pay higher out-of-pocket costs than with the Blue Choice OPT PPO network.

Tier 1	Tier 2	Tier 3
Pay the least out-of-pocket expenses by using a participating provider in the Blue Choice OPT PPO network.	Pay additional out-of-pocket costs by choosing a participating provider in the larger, statewide PPO network.	Pay the highest out-of-pocket costs by selecting an out-of-network provider and may be required to pay those fees up front.

### Compare Costs

The example shows how costs and savings vary by tier. Even though a specific plan design may be different, it may make sense to use a doctor or hospital in tier 1, the statewide Blue Choice Options PPO network, or tier 2, the larger, statewide PPO network.

	Tier 1: Statewide Blue Choice Options PPO Network	Tier 2: Larger Statewide PPO Network	Tier 3: Out-of-Network*
Doctor Visit	Cost is \$200 You pay \$20	Cost is \$200 You pay \$30	Cost is \$200 You pay \$200
Specialist Visit	Cost is \$200 You pay \$30	Cost is \$200 You pay \$50	Cost is \$200 You pay \$200
2-Day Inpatient Hospital Stay	Cost is \$5,000 You pay \$1,400	Cost is \$5,000 You pay \$2,900	Cost is \$5,000 You pay \$5,000

\*Applied to member's deductible. Once deductible is met, pays at percentage designated by plan. Benefit information is based on a \$1,000 deductible and 90% coinsurance for tier 1, a \$2,000 deductible and 70% coinsurance for tier 2, and a \$8,000 deductible and 50% coinsurance for OON. These examples are stand-alone and do not track the member's out-of-pocket max.

### Finding a Tier 1 or Tier 2 Provider

To find a participating Blue Choice Options PPO provider, visit **bcbsil.com** and select **Find Care**. Follow the prompts. Then, select **Blue Choice Options** from the network drop-down list or provider type. You can narrow search by specialty, patient ratings and more. You may also narrow your search to Tier 1 Providers only or All Tier Providers.

# Medical



BlueCross BlueShield  
of Illinois

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

## HMO Plan<sup>A</sup> (NHHB103)

### Blue Advantage HMO Network

#### In-Network Only

<b>Calendar Year Deductible</b>	Not Applicable
<b>Calendar Year Out-of-Pocket Maximum</b> (includes deductible, coinsurance and applicable copays except pharmacy)	<p><i>Does <u>not</u> include the Prescription Drug Out-of-Pocket Maximum</i></p> <p>\$1,500 individual \$3,000 family</p>
<b>Office Visit</b>	
Primary Provider	\$20 copay then plan pays 100%
Specialist	\$40 copay then plan pays 100%
Virtual Visit	Not Applicable
<b>Preventive Services</b>	Plan pays 100%
<b>Lab and X-ray</b>	Plan pays 100%
<b>Inpatient Hospitalization</b>	Plan pays 100%
<b>Outpatient Surgery</b>	Plan pays 100%
<b>Urgent Care</b> (copay may apply)	Plan pays 100% (must be affiliated with chosen medical group)
<b>Emergency Room</b> (copay waived if admitted on an inpatient basis)	\$150 copay then plan pays 100%

<sup>A</sup>Requires selection of a Primary Care Physician and Medical Group.



# Medical



## \$500 PPO Plan (MPP73436)

## Blue Choice Select \$750 PPO Plan (MIBCS2035) (Illinois Residents Only)

	Participating Provider Organization Network		Blue Choice Select Network	
	In-Network	Out-Of-Network <sup>A</sup>	In-Network	Out-Of-Network <sup>A</sup>
<b>Calendar Year Deductible</b>	\$500 individual \$1,500 family	\$1,000 individual \$3,000 family	\$750 individual \$2,250 family	\$1,500 individual \$4,500 family
<b>Calendar Year Out-of-Pocket Maximum</b> (includes deductible, coinsurance and applicable copays except pharmacy)	<i>Does <u>not</u> include the Prescription Drug Out-of-Pocket Maximum</i>		<i>Prescription Drug Copayments included within the Medical Out-of-Pocket Maximum</i>	
	\$2,500 individual \$7,500 family	\$5,000 individual \$15,000 family	\$3,000 individual \$9,000 family	\$9,000 individual \$27,000 family
<b>Office Visit</b>				
Primary Provider	\$30 copay then plan pays 100%	Plan pays 60% after deductible	\$25 copay then plan pays 100%	Plan pays 50% after deductible
Specialist	\$50 copay then plan pays 100%	Plan pays 60% after deductible	\$25 copay then plan pays 100%	Plan pays 50% after deductible
Virtual Visit	\$30 copay then plan pays 100%	Not Applicable	Plan pays 100%	Not Applicable
<b>Preventive Services</b>	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 50% after deductible
<b>Lab and X-ray</b>	Complex Imaging: plan pays 80% after deductible All Other: \$30 or \$50 copay then plan pays 100%	Plan pays 60% after deductible	Complex Imaging: plan pays 80% after deductible All Other: \$25 copay then plan pays 100%	Plan pays 50% after deductible
<b>Inpatient Hospitalization</b>	Plan pays 80% after deductible	\$300 copay then plan pays 60% after deductible	Plan pays 80% after deductible	\$300 copay then plan pays 50% after deductible
<b>Outpatient Surgery</b>	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
<b>Urgent Care</b> (copay may apply)	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
<b>Emergency Room</b> (copay waived if admitted on an inpatient basis)	\$150 copay then plan pays 100%		\$200 copay then plan pays 100%	

<sup>A</sup>Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.

# Medical



## Blue Choice Options \$500 PPO Plan (MIBCO2085)

Blue Choice Options Network- Plan MIBCO2085- Plan #1			
	Blue Choice (Tier 1)	PPO (Tier 2)	Out-Of-Network <sup>B</sup>
<b>Calendar Year Deductible</b>	\$500 individual \$1,500 family	\$1,250 individual \$3,750 family	\$2,500 individual \$7,500 family
<b>Calendar Year Out-of-Pocket Maximum</b> (includes deductible, coinsurance and applicable copays)	\$1,250 individual \$2,500 family	\$1,500 individual \$4,500 family	\$4,500 individual \$9,000 family
<b>Office Visit</b>			
Primary Provider	\$25 copay then plan pays 100%	\$45 copay then plan pays 100%	Plan pays 50% after deductible
Specialist	\$50 copay then plan pays 100%	\$90 copay then plan pays 100%	Plan pays 50% after deductible
Virtual Visit	\$20 copay then plan pays 100%	\$20 copay then plan pays 100%	Not Applicable
<b>Preventive Services</b>	Plan pays 100%	Plan pays 100%	Plan pays 50% after deductible
<b>Lab and X-ray</b>	Complex Imaging: plan pays 90% after deductible All Other: \$25 or \$50 copay then plan pays 100%	Complex Imaging: plan pays 70% after deductible All Other: \$45 or \$90 copay then plan pays 100%	Plan pays 50% after deductible
<b>Inpatient Hospitalization</b>	\$250 copay then plan pays 90% after deductible	\$500 copay then plan pays 70% after deductible	\$600 copay then plan pays 50% after deductible
<b>Outpatient Surgery</b>	\$200 copay then plan pays 90% after deductible	\$400 copay then plan pays 70% after deductible	\$500 copay then plan pays 50% after deductible
<b>Urgent Care</b>	\$75 copay then plan pays 100%	\$75 copay then plan pays 100%	\$75 copay then plan pays 100%
<b>Emergency Room</b>	\$400 copay then plan pays 90% after deductible		

<sup>B</sup>Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates

# Medical



## Blue Choice Options \$750 PPO Plan (MIBCO2005)

Blue Choice Options Network- Plan MIBCO2005- Plan #2			
	Blue Choice (Tier 1)	PPO (Tier 2)	Out-Of-Network <sup>B</sup>
<b>Calendar Year Deductible</b>	\$750 individual \$2,250 family	\$1,750 individual \$5,250 family	\$3,500 individual \$10,500 family
<b>Calendar Year Out-of-Pocket Maximum</b> (includes deductible, coinsurance and applicable copays)	\$4,500 individual \$9,000 family	\$6,100 individual \$12,200 family	\$18,300 individual \$36,600 family
<b>Office Visit</b>			
Primary Provider	\$25 copay then plan pays 100%	\$55 copay then plan pays 100%	Plan pays 50% after deductible
Specialist	\$50 copay then plan pays 100%	\$110 copay then plan pays 100%	Plan pays 50% after deductible
Virtual Visit	\$20 copay then plan pays 100%	\$20 copay then plan pays 100%	Not Applicable
<b>Preventive Services</b>	Plan pays 100%	Plan pays 100%	Plan pays 50% after deductible
<b>Lab and X-ray</b>	Complex Imaging: plan pays 90% after deductible All Other: \$25 or \$50 copay then plan pays 100%	Complex Imaging: plan pays 70% after deductible All Other: \$55 or \$110 copay then plan pays 100%	Plan pays 50% after deductible
<b>Inpatient Hospitalization</b>	\$250 copay then plan pays 90% after deductible	\$500 copay then plan pays 70% after deductible	\$600 copay then plan pays 50% after deductible
<b>Outpatient Surgery</b>	\$200 copay then plan pays 90% after deductible	\$400 copay then plan pays 70% after deductible	\$500 copay then plan pays 50% after deductible
<b>Urgent Care</b>	\$75 copay then plan pays 100%	\$75 copay then plan pays 100%	\$75 copay then plan pays 100%
<b>Emergency Room</b>	\$400 copay then plan pays 90% after deductible		

<sup>B</sup>Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates



# Prescription Drugs



Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

## HMO Plan (NHHB103)

In-Network Only	
Calendar Year Out-of-Pocket Limit	<i>Separate from the Medical Out-of-Pocket Maximum</i> \$1,000 individual \$3,000 family
<b>Pharmacy</b>	
Preferred Generic	\$15 copay
Non-Preferred Generic	\$15 copay
Preferred Brand	\$30 copay
Non-Preferred Brand	\$50 copay
Select Oral Contraceptives	\$0 copay
Supply Limit	30 days
<b>Mail Order</b>	
Preferred Generic	\$30 copay
Non-Preferred Generic	\$30 copay
Preferred Brand	\$60 copay
Non-Preferred Brand	\$100 copay
Specialty (limited to a 30 day supply)	Covered at applicable copay
Select Oral Contraceptives	\$0 copay
Supply Limit	90 days

# Prescription Drugs



**PPO Plans Only:** All CVS pharmacies (including those located in Target stores) are not part of the BCBSIL PPO pharmacy network. Preferred pharmacies include Walgreens, Wal-Mart, Albertsons/Osco and Access Health.

## \$500 PPO Plan<sup>A</sup> (MPP73436)

## Blue Choice \$750 PPO Plan<sup>A</sup> (MIBCS2035) (Illinois Residents Only)

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
<b>Calendar Year Out-of-Pocket Limit</b>	<i>Separate from the Medical Out-of-Pocket Maximum</i> \$1,000 individual \$3,000 family		<i>Prescription Drug Copayments included within the Medical Out-of-Pocket Maximum</i>	
<b>Pharmacy</b>	<b><i>Preferred/Non-Preferred Network Pharmacies</i></b>	<b><i>Covered at 75% of contracted pharmacy amount after appropriate copay</i></b>	<b><i>Preferred/Non-Preferred Network Pharmacies</i></b>	<b><i>Covered at 50% of contracted pharmacy amount after appropriate copay</i></b>
Preferred Generic	\$10/\$15 copay	\$15 copay	\$5/\$15 copay	\$15 copay
Non-Preferred Generic	\$10/\$15 copay	\$15 copay	\$15/\$25 copay	\$25 copay
Preferred Brand	\$40/\$50 copay	\$50 copay	\$60/\$80 copay	\$80 copay
Non-Preferred Brand	\$60/\$70 copay	\$70 copay	\$110/\$130 copay	\$130 copay
Select Oral Contraceptives	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Supply Limit	30 days	30 days	30 days	30 days
<b>Mail Order</b>				
Preferred Generic	\$20 copay	Not Applicable	\$15 copay	Not Applicable
Non-Preferred Generic	\$20 copay		\$45 copay	
Preferred Brand	\$80 copay		\$180 copay	
Non-Preferred Brand	\$120 copay		\$330 copay	
Specialty (limited to a 30 day supply)	Covered at applicable copay		Covered at applicable copay	
Select Oral Contraceptives	\$0 copay		\$0 copay	
Supply Limit	90 days		90 days	

<sup>A</sup>If a brand name drug is requested when there is a generic equivalent available, member will pay the difference between the brand name cost and generic equivalent cost, plus the appropriate brand name copay. Only the prescription drug copay amount will count toward the prescription drug total out-of-pocket maximum.

# Prescription Drugs

**PPO Plans Only:** All CVS pharmacies (including those located in Target stores) are not part of the BCBSIL PPO pharmacy network. Preferred pharmacies include Walgreens, Wal-Mart, Albertsons/Osco and Access Health.

### Blue Choice Options \$500 PPO Plan<sup>A</sup> (MIBCO2085)

	Blue Choose (Tier 1)	PPO (Tier 2)	Out-Of-Network
<b>Pharmacy</b>	<b>Preferred/Non-Preferred Network Pharmacies</b>		<i>Covered at 50% of contracted pharmacy amount after appropriate copay</i>
Preferred Generic	\$5/\$15 copay	\$5/\$15 copay	\$15 copay
Non-Preferred Generic	\$15/\$25 copay	\$15/\$25 copay	\$25 copay
Preferred Brand	\$45/\$65 copay	\$45/\$65 copay	\$65 copay
Non-Preferred Brand	\$85/\$105 copay	\$85/\$105 copay	\$105 copay
Select Oral Contraceptives	\$0 copay	\$0 copay	\$0 copay
Supply Limit	30 days	30 days	30 days
<b>Mail Order</b>			
Preferred Generic	\$15 copay	\$15 copay	Not Applicable
Non-Preferred Generic	\$45 copay	\$45 copay	
Preferred Brand	\$135 copay	\$135 copay	
Non-Preferred Brand	\$255 copay	\$255 copay	
Specialty (limited to a 30 day supply)	Covered at applicable copay	Covered at applicable copay	
Supply Limit	90 days	90 days	

<sup>A</sup>If a brand name drug is requested when there is a generic equivalent available, member will pay the difference between the brand name cost and generic equivalent cost, plus the appropriate brand name percentage. Only the prescription drug percentage amount will count toward the total out-of-pocket maximum.

## Prescription Drugs

**PPO Plans Only: All CVS pharmacies (including those located in Target stores) are not part of the BCBSIL PPO pharmacy network. Preferred pharmacies include Walgreens, Wal-Mart, Albertsons/Osco and Access Health.**

**Blue Choice Options \$750 PPO Plan<sup>A</sup> (MIBCO2005)**

	<b>Blue Choose (Tier 1)</b>	<b>PPO (Tier 2)</b>	<b>Out-Of-Network</b>
<b>Pharmacy</b>	<b><i>Preferred/Non-Preferred Network Pharmacies</i></b>		<i>Covered at 50% of contracted pharmacy amount after appropriate copay</i>
Preferred Generic	\$5/\$15 copay	\$5/\$15 copay	\$15 copay
Non-Preferred Generic	\$15/\$25 copay	\$15/\$25 copay	\$25 copay
Preferred Brand	\$45/\$65 copay	\$45/\$65 copay	\$65 copay
Non-Preferred Brand	\$85/\$105 copay	\$85/\$105 copay	\$105 copay
Select Oral Contraceptives	\$0 copay	\$0 copay	\$0 copay
Supply Limit	30 days	30 days	30 days
<b>Mail Order</b>			
Preferred Generic	\$15 copay	\$15 copay	Not Applicable
Non-Preferred Generic	\$45 copay	\$45 copay	
Preferred Brand	\$135 copay	\$135 copay	
Non-Preferred Brand	\$255 copay	\$255 copay	
Specialty (limited to a 30 day supply)	Covered at applicable copay	Covered at applicable copay	
Supply Limit	90 days	90 days	

<sup>A</sup>If a brand name drug is requested when there is a generic equivalent available, member will pay the difference between the brand name cost and generic equivalent cost, plus the appropriate brand name percentage. Only the prescription drug percentage amount will count toward the total out-of-pocket maximum.

## Mokena School District #159

BCBSIL Hospital Listing (Organization Name)	Service Address 1	Service City	Service State	Service Zip Code	Service County	Blue Advantage HMO (BAHMO)	Blue Choice Options (BCO)	Blue Choice PPO Select (BCS)	Preferred Provider Option (PPO)
ABRAHAM LINCOLN MEM HOSPITAL	200 STAHLHUT DR	LINCOLN	IL	62656	Logan	X	X		X
ADVOCATE CHRIST HOSP MED CNTR	4440 W 95TH ST	OAK LAWN	IL	60453	Cook	X	X		X
ADVOCATE CONDELL MEDICAL CENTER	801 S MILWAUKEE AVE	LIBERTYVILLE	IL	60048	Lake	X	X		X
ADVOCATE GOOD SAMARITAN HOSPITAL	3815 HIGHLAND AVE	DOWNERS GROVE	IL	60515	DuPage	X	X		X
ADVOCATE GOOD SHEPHERD HOSPITAL	450 W IL HWY 22	BARRINGTON	IL	60010	Lake	X	X		X
ADVOCATE HOPE CHILDRENS HOSPITAL	4440 W 95TH ST	OAK LAWN	IL	60453	Cook		X		X
ADVOCATE ILLINOIS MASONIC MED CNT	836 W WELLINGTON AVE	CHICAGO	IL	60657	Cook	X	X		X
ADVOCATE LUTHERAN GEN CHILDREN	1775 DEMPSTER ST	PARK RIDGE	IL	60068	Cook		X		X
ADVOCATE LUTHERAN GENERAL HOSP	1775 DEMPSTER ST	PARK RIDGE	IL	60068	Cook	X	X		X
ADVOCATE SHERMAN HOSPITAL	1425 N RANDALL RD	ELGIN	IL	60123	Kane	X	X		X
ADVOCATE SOUTH SUBURBAN HOSPITAL	17800 S KEDZIE AVE	HAZEL CREST	IL	60429	Cook	X	X		X
ADVOCATE TRINITY HOSPITAL	2320 E 93RD ST	CHICAGO	IL	60617	Cook	X	X		X
ALEXIAN BROTHERS BEHAVIORAL HLTH	1650 MOON LAKE BLVD	HOFFMAN ESTATES	IL	60194	Cook		X	X	X
ALEXIAN BROTHERS MEDICAL CENTER	800 BIESTERFIELD RD	ELK GROVE VILLAGE	IL	60007	Cook	X	X	X	X
ALEXIAN BRTHRS CTR FOR MNTL HLTH	3436 N KENNICOTT AVE	ARLINGTON HEIGHTS	IL	60005	Cook		X	X	X
ANDERSON HOSPITAL	6800 STATE RT 162	MARYVILLE	IL	62062	Madison	X	X	X	X
ANDERSON REHABILITATION INSTITUTE	3402 ANDERSON HEALTHCARE DR	EDWARDSVILLE	IL	62025	Madison		X	X	X
BLESSING HOSPITAL	1005 BROADWAY ST	QUINCY	IL	62301	Adams		X	X	X
BLOOMINGTON VA CLINIC	207 E HAMILTON RD	BLOOMINGTON	IL	61704	McLean				X
CANCER TREATMENT CTR OF AMERICA	2520 ELISHA AVE AVE	ZION	IL	60099	Lake				X
CARLE BROMENN MEDICAL CENTER	1304 FRANKLIN AVE	NORMAL	IL	61761	McLean		X	X	X
CARLE EUREKA HOSPITAL	101 S MAJOR ST	EUREKA	IL	61530	Woodford		X	X	X
CARLE FOUNDATION HOSP	611 W PARK ST	URBANA	IL	61801	Champaign		X	X	X
CARLE HEALTH METHODIST HOSPITAL	221 NE GLEN OAK AVE	PEORIA	IL	61636	Peoria		X	X	X
CARLE HEALTH PEKIN HOSPITAL	600 S 13TH ST	PEKIN	IL	61554	Tazewell			X	X
CARLE HEALTH PROCTOR HOSPITAL	5409 N KNOXVILLE AVE	PEORIA	IL	61614	Peoria			X	X
CARLINVILLE AREA HOSP	20733 N BROAD ST	CARLINVILLE	IL	62626	Macoupin		X	X	X
CENTRAL DUPAGE HOSPITAL	25 N WINFIELD RD	WINFIELD	IL	60190	DuPage	X	X	X	X
CGH MEDICAL CENTER	100 E LE FEVRE RD	STERLING	IL	61081	Whiteside		X	X	X
CGH MEDICAL CENTER	101 E MILLER RD	STERLING	IL	61081	Whiteside				X
CHICAGO BEHAVIORAL HOSPITAL	555 WILSON LN	DES PLAINES	IL	60016	Cook				X
CLAY COUNTY HOSPITAL	911 STACY BURK DR	FLORA	IL	62839	Clay		X	X	X
COMMUNITY FIRST MEDICAL CENTER	5645 W ADDISON ST	CHICAGO	IL	60634	Cook	X	X	X	X
COMMUNITY HOSPITAL	901 MACARTHUR BLVD	MUNSTER	IN	46321	Lake	X			
COMMUNITY MEMORIAL HOSP ASSOC	400 N CALDWELL ST	STAUNTON	IL	62088	Macoupin			X	X
COPLEY MEMORIAL HOSPITAL	2000 OGDEN AVE	AURORA	IL	60504	Kane	X	X	X	X
CRAWFORD MEMORIAL HOSPITAL	1000 N ALLEN ST	ROBINSON	IL	62454	Crawford		X	X	X
CROSSROADS COMMUNITY HOSPITAL	8 DOCTORS PARK RD	MOUNT VERNON	IL	62864	Jefferson		X	X	X
DECATUR MEMORIAL HOSPITAL	2300 N EDWARD ST	DECATUR	IL	62526	Macon		X	X	X
DELNOR COMMUNITY HOSPITAL	300 RANDALL RD	GENEVA	IL	60134	Kane	X	X	X	X
EDWARD HINES JR HOSPITAL	5000 S 5TH AVE	HINES	IL	60141	Cook			X	X
EDWARD HOSPITAL	801 S WASHINGTON ST	NAPERVILLE	IL	60540	DuPage	X	X	X	X

BCBSIL Hospital Listing (Organization Name)	Service Address 1	Service City	Service State	Service Zip Code	Service County	Blue Advantage HMO (BAHMO)	Blue Choice Options (BCO)	Blue Choice PPO Select (BCS)	Preferred Provider Option (PPO)
ELMHURST MEM HOSPITAL MAIN CAMPUS	155 E BRUSH HILL RD	ELMHURST	IL	60126	DuPage	X	X	X	X
ENCOMPASS HEALTH REHABILITATION	1201 AMERICAN WAY	LIBERTYVILLE	IL	60048	Lake		X	X	X
ENCOMPASS HLTH DEACONESS REHAB	9355 WARRICK TRL	NEWBURGH	IN	47630	Warrick				
FAIRFIELD MEMORIAL HOSPITAL	303 NW 11TH ST	FAIRFIELD	IL	62837	Wayne		X	X	X
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST	VANDALIA	IL	62471	Fayette		X	X	X
FERRELL HOSPITAL	1201 PINE ST	ELDORADO	IL	62930	Saline		X	X	X
FINLEY HOSPITAL	350 N GRANDVIEW AVE	DUBUQUE	IA	52001	Dubuque				
FOGLIA FAMILY FOUNDATION RESIDENT	801 GLOUCESTER DR	ELK GROVE VILLAGE	IL	60007	Cook		X	X	X
FRANCISCAN HEALTH CROWN POINT	12750 SAINT FRANCIS DR	CROWN POINT	IN	46307	Lake				X
FRANCISCAN HEALTH OLYMPIA FIELDS	20201 CRAWFORD AVE	OLYMPIA FIELDS	IL	60461	Cook	X	X	X	X
FRANCISCAN ST MARGARET HLTH DYER	24 JOLIET ST	DYER	IN	46311	Lake	X			X
FRANKLIN HOSPITAL DISTRICT	201 BAILEY LN	BENTON	IL	62812	Franklin		X	X	X
FREEPORT MEMORIAL HOSP	1045 W STEPHENSON ST	FREEPORT	IL	61032	Stephenson		X	X	X
FREEPORT VA	750 KIWANIS DR	FREEPORT	IL	61032	Stephenson			X	X
GATEWAY REGIONAL	2100 MADISON AVE	GRANITE CITY	IL	62040	Madison		X	X	X
GATEWAY REGIONAL MEDICAL CNTR	2100 MADISON AVE	GRANITE CITY	IL	62040	Madison				
GENESIS MEDICAL CENTER ALEDO	409 NW 9TH AVE	ALEDO	IL	61231	Mercer		X	X	X
GENESIS MEDICAL CENTER SILVIS	801 ILLINI DR	SILVIS	IL	61282	Rock Island				X
GIBSON COMMUNITY HOSP ASSOC	1120 N MELVIN ST	GIBSON CITY	IL	60936	Ford		X	X	X
GOOD SAMARITAN HOSPITAL	520 S SEVENTH ST	VINCENNES	IN	47591	Knox				
GOTTLIEB MEMORIAL HOSPITAL	701 W NORTH AVE	MELROSE PARK	IL	60160	Cook	X	X	X	X
GRAHAM HOSPITAL ASSOCIATION	210 W WALNUT ST	CANTON	IL	61520	Fulton			X	X
HAMILTON MEMORIAL HOSP	611 S MARSHALL AVE	MC LEANSBORO	IL	62859	Hamilton		X	X	X
HAMMOND HENRY DISTRICT HOSP	600 N COLLEGE AVE	GENESEO	IL	61254	Henry		X	X	X
HARDIN COUNTY GENERAL HOSP	6 FERRELL RD	ROSICLARE	IL	62982	Hardin			X	X
HARRISBURG MEDICAL CENTER	100 DR WARREN TUTTLE DR	HARRISBURG	IL	62946	Saline		X	X	X
HARTGROVE HOSPITAL	5730 W ROOSEVELT RD	CHICAGO	IL	60644	Cook		X		X
HEARTLAND REGIONAL MEDICAL CENTER	3333 W DEYOUNG ST	MARION	IL	62959	Williamson		X	X	X
HERRIN HOSPITAL	201 S 14TH ST	HERRIN	IL	62948	Williamson		X	X	X
HILLSBORO AREA HOSPITAL	1200 E TREMONT ST	HILLSBORO	IL	62049	Montgomery		X		X
HLTH ST JOSEPH HOSP LAKE ST LOUIS	100 MEDICAL PLAZA	LAKE SAINT LOUIS	MO	63367	St. Charles				
HOLY CROSS HOSPITAL	2701 W 68TH ST	CHICAGO	IL	60629	Cook	X	X	X	X
HOOPESTON COMMUNITY MEMORIAL HOSP	701 E ORANGE ST	HOOPESTON	IL	60942	Vermilion		X	X	X
HOPEDALE HOSPITAL	107 TREMONT ST	HOPEDALE	IL	61747	Tazewell		X	X	X
HSBS GOOD SHEPHERD HOSPITAL	200 S CEDAR ST	SHELBYVILLE	IL	62565	Shelby		X	X	X
HSBS HOLY FAMILY HOSPITAL	200 HEALTH CARE DR	GREENVILLE	IL	62246	Bond		X	X	X
HUMBOLDT PARK HEALTH	1044 N FRANCISCO AVE	CHICAGO	IL	60622	Cook	X	X	X	X
ILLINI COMMUNITY HOSPITAL	640 W WASHINGTON ST	PITTSFIELD	IL	62363	Pike		X	X	X
INGALLS MEMORIAL HOSPITAL	1 INGALLS DR	HARVEY	IL	60426	Cook	X			X
INSIGHT HOSPITAL MEDICAL CTR CHI	2525 S MICHIGAN AVE	CHICAGO	IL	60616	Cook		X	X	X
IROQUOIS MEMORIAL HOSPITAL	200 E FAIRMAN AVE	WATSEKA	IL	60970	Iroquois		X	X	X
JACKSON PARK HOSPITAL	7531 S STONY ISLAND AVE	CHICAGO	IL	60649	Cook	X	X	X	X
JAVON BEA HOSPITAL	2400 N ROCKTON AVE	ROCKFORD	IL	61103	Winnebago				X
JAVON BEA HOSPITAL	8201 E RIVERSIDE BLVD	ROCKFORD	IL	61114	Boone				X
JERSEY COMMUNITY HOSPITAL	400 MAPLE SUMMIT RD	JERSEYVILLE	IL	62052	Jersey		X	X	X
JOHN H STROGER JR HOSP COOK CNTY	1901 W HARRISON ST	CHICAGO	IL	60612	Cook	X	X	X	X
KATHERINE SHAW BETHEA HOSPITAL	403 E 1ST ST	DIXON	IL	61021	Lee		X	X	X
KINDRED CHGO CENTRAL HOSPITAL	4058 W MELROSE ST	CHICAGO	IL	60641	Cook		X	X	X



BCBSIL Hospital Listing (Organization Name)	Service Address 1	Service City	Service State	Service Zip Code	Service County	Blue Advantage HMO (BAHMO)	Blue Choice Options (BCO)	Blue Choice PPO Select (BCS)	Preferred Provider Option (PPO)
KINDRED CHICAGO LAKESHORE	6130 N SHERIDAN RD	CHICAGO	IL	60660	Cook		X	X	X
KINDRED HOSPITAL - SYCAMORE	225 EDWARD ST	SYCAMORE	IL	60178	DeKalb		X	X	X
KINDRED HOSPITAL CHGO NO CAMPUS	365 E NORTH AVE	NORTHLAKE	IL	60164	Cook		X	X	X
KINDRED HOSPITAL CHGO NRTH CAMPUS	2544 W MONTROSE AVE	CHICAGO	IL	60618	Cook		X	X	X
KIRBY MEDICAL CENTER	1000 MEDICAL CENTER DR	MONTICELLO	IL	61856	Piatt		X	X	X
KISHWAUKEE COMMUNITY HOSPITAL	1 KISH HOSPITAL DR	DEKALB	IL	60115	DeKalb	X	X	X	X
LA RABIDA CHILDRENS HOSPITAL	6501 S PROMONTORY DR	CHICAGO	IL	60649	Cook		X	X	X
LAWRENCE COUNTY MEMORIAL HOSPITAL	2200 STATE ST	LAWRENCEVILLE	IL	62439	Lawrence		X		X
LINCOLN PRAIRIE BEHAVIORAL HLTH	5230 6TH STREET FRONTAGE RD E	SPRINGFIELD	IL	62703	Sangamon				X
LORETTO HOSPITAL	1000 MADISON ST	OAK PARK	IL	60302	Cook		X	X	X
LOUIS A WEISS MEMORIAL HOSPITAL	4646 N MARINE DR	CHICAGO	IL	60640	Cook		X	X	X
LOYOLA UNIVERSITY MEDICAL CENTER	2160 S 1ST AVE	MAYWOOD	IL	60153	Cook	X	X	X	X
LURIE CHILDRENS HOSPITAL CHGO	225 E CHICAGO AVE	CHICAGO	IL	60611	Cook				X
MACNEAL HOSPITAL	3249 OAK PARK AVE	BERWYN	IL	60402	Cook	X	X	X	X
MARIANJOY REHABILITATION HOSPITAL	26W171 ROOSEVELT RD	WHEATON	IL	60187	DuPage		X	X	X
MARSHALL BROWNING HOSP ASSOC	900 N WASHINGTON ST	DU QUOIN	IL	62832	Perry		X	X	X
MASON DISTRICT HOSPITAL	615 N PROMENADE ST	HAVANA	IL	62644	Mason		X	X	X
MASSAC MEMORIAL HOSPITAL	28 CHICK ST	METROPOLIS	IL	62960	Massac		X	X	X
MCDONOUGH DISTRICT HOSP	525 E GRANT ST	MACOMB	IL	61455	McDonough			X	X
MEMORIAL HOSP OF CARBONDALE	405 W JACKSON	CARBONDALE	IL	62902	Jackson		X	X	X
MEMORIAL HOSPITAL	1454 N COUNTY RD 2050	CARTHAGE	IL	62321	Hancock		X	X	X
MEMORIAL HOSPITAL	4500 MEMORIAL DR	BELLEVILLE	IL	62226	Saint Clair	X	X	X	X
MEMORIAL HOSPITAL	1900 STATE ST	CHESTER	IL	62233	Randolph		X	X	X
MEMORIAL HOSPITAL EAST	1404 CROSS ST	SHILOH	IL	62269	Saint Clair		X	X	X
MEMORIAL MEDICAL CENTER	701 N 1ST ST	SPRINGFIELD	IL	62702	Sangamon	X	X		X
MERCY HARVARD HOSPITAL	901 GRANT ST	HARVARD	IL	60033	McHenry				X
MERCY HEALTH HOSP & PHYS CRY LAKE	875 S ROUTE 31	CRYSTAL LAKE	IL	60014	McHenry				X
METHODIST HOSPITAL SOUTHLAKE	8701 BROADWAY	MERRILLVILLE	IN	46410	Lake				X
MIDWEST MEDICAL CENTER	ONE MEDICAL CENTER DR	GALENA	IL	61036	Jo Daviess		X	X	X
MORRIS HOSPITAL	150 W HIGH ST	MORRIS	IL	60450	Grundy		X	X	X
MORRISON COMMUNITY HOSP	303 N JACKSON ST	MORRISON	IL	61270	Whiteside		X	X	X
MOUNT SINAI HOSPITAL	1500 S. CALIFORNIA	CHICAGO	IL	60608	Cook	X	X	X	X
NORTHSHORE EVANSTON HOSPITAL	2650 RIDGE AVE	EVANSTON	IL	60201	Cook	X	X	X	X
NORTHSHORE GLENBROOK HOSPITAL	2100 PFINGSTEN RD	GLENVIEW	IL	60026	Cook	X	X	X	X
NORTHSHORE HIGHLAND PARK HOSPITAL	777 PARK AVE WEST	HIGHLAND PARK	IL	60035	Lake		X	X	X
NORTHSHORE SKOKIE HOSPITAL	9600 GROSS POINT RD	SKOKIE	IL	60076	Cook	X	X	X	X
NORTHWEST COMMUNITY HOSPITAL	800 W CENTRAL RD	ARLINGTON HEIGHTS	IL	60005	Cook	X	X	X	X
NORTHWESTERN LAKE FOREST HOSPITAL	1000 N WESTMORELAND RD	LAKE FOREST	IL	60045	Lake		X	X	X
NORTHWESTERN MEDICINE HUNTLEY HOS	10400 HALIGUS RD	HUNTLEY	IL	60142	McHenry	X	X	X	X
NORTHWESTERN MEDICINE MCHENRY HOS	4201 W MEDICAL CENTER DR	MCHENRY	IL	60050	McHenry	X	X	X	X
NORTHWESTERN MEDICINE WOODSTOCK	3701 DOTY RD	WOODSTOCK	IL	60098	McHenry	X	X	X	X
NORTHWESTERN MEMORIAL HOSPITAL	251 E HURON	CHICAGO	IL	60611	Cook		X	X	X
OSF HEALTHCARE TRANSITION HOS ARU	500 W ROMEO B GARRETT AVE	PEORIA	IL	61605	Peoria		X	X	X
OSF HEART OF MARY MEDICAL CENTER	1400 W PARK	URBANA	IL	61801	Champaign		X	X	X
OSF HOLY FAMILY MEDICAL CENTER	1000 W HARLEM AVE	MONMOUTH	IL	61462	Warren		X	X	X
OSF LITTLE COMPANY OF MARY MED CN	2800 W 95TH ST	EVERGREEN PK	IL	60805	Cook	X	X	X	X
OSF SAINT ANTHONY'S HEALTH	1 ST ANTHONYS WAY	ALTON	IL	62002	Madison		X	X	X
OSF SAINT CLARE MEDICAL CENTER	530 PARK AVE E	PRINCETON	IL	61356	Bureau		X	X	X

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OSF SAINT ELIZABETH MEDICAL CENTE	1100 E NORRIS DR	OTTAWA	IL	61350	La Salle		X	X	X
OSF SAINT LUKE MEDICAL CENTER	1051 W SOUTH ST	KEWANEE	IL	61443	Henry		X	X	X
OSF SAINT PAUL MEDICAL CENTER	1401 E 12TH ST	MENDOTA	IL	61342	La Salle		X	X	X
OSF ST FRANCIS MEDICAL CENTER	530 N E GLEN OAK AVE	PEORIA	IL	61637	Peoria	X	X	X	X
PALOS COMMUNITY HOSPITAL	12251 S 80TH AVE	PALOS HEIGHTS	IL	60463	Cook	X	X	X	X
PANA COMMUNITY HOSP	101 E NINTH ST	PANA	IL	62557	Christian		X	X	X
PARIS COMMUNITY HOSPITAL	721 E COURT ST	PARIS	IL	61944	Edgar		X	X	X
PASSAVANT MEMORIAL AREA HOSP	1600 W WALNUT	JACKSONVILLE	IL	62650	Morgan	X	X	X	X
PINCKNEYVILLE COMMUNITY HOSP	5383 STATE ROUTE 154	PINCKNEYVILLE	IL	62274	Perry			X	X
PRESENCE HOLY FAMILY MEDICAL CTR	100 N RIVER RD	DES PLAINES	IL	60016	Cook		X	X	X
PRESENCE MERCY MEDICAL CENTER	1325 N HIGHLAND AVE	AURORA	IL	60506	Kane	X	X	X	X
PRESENCE RESURRECTION MED CTR	7435 W TALCOTT AVE	CHICAGO	IL	60631	Cook	X	X	X	X
PRESENCE ST FRANCIS HOSPITAL	355 RIDGE AVE	EVANSTON	IL	60202	Cook	X	X	X	X
PRESENCE ST JOSEPH HOSP CHICAGO	2900 N LAKE SHORE DR	CHICAGO	IL	60657	Cook	X	X	X	X
PRESENCE ST JOSEPH HOSP ELGIN	77 N AIRLITE ST	ELGIN	IL	60123	Kane	X	X	X	X
PRESENCE ST JOSEPH MEDICAL CTR	333 N MADISON ST	JOLIET	IL	60435	Will	X	X	X	X
PRESENCE ST MARY ELIZABETH MDC	2233 W DIVISION ST	CHICAGO	IL	60622	Cook		X	X	X
PRESENCE ST MARYS HOSPITAL	500 W COURT ST	KANKAKEE	IL	60901	Kankakee	X	X	X	X
PROVIDENT HOSPITAL OF COOK COUNTY	500 E 51ST ST	CHICAGO	IL	60615	Cook	X	X	X	X
RANKEN JORDAN PEDIATRIC SPEC HOSP	11365 DORSETT RD	MARYLAND HEIGHTS	MO	63043	St. Louis				
RED BUD REGIONAL HOSPITAL	325 SPRING ST	RED BUD	IL	62278	Randolph		X	X	X
REHAB WITHOUT WALLS NEURO REHAB	1040 ROBEY AVE	DOWNERS GROVE	IL	60516	DuPage		X	X	X
REHABILITATION INSTITUTE SOUTH IL	2351 FRANK SCOTT PKWY E	BELLEVILLE	IL	62269	Saint Clair		X	X	X
RICHLAND MEMORIAL HOSPITAL INC	800 E LOCUST ST	OLNEY	IL	62450	Richland		X	X	X
RIVEREDGE HOSPITAL	8311 ROOSEVELT RD	FOREST PARK	IL	60130	Cook		X	X	X
RIVERSIDE MEDICAL CENTER	350 N WALL ST	KANKAKEE	IL	60901	Kankakee		X	X	X
RML CHICAGO	3435 W VAN BUREN	CHICAGO	IL	60624	Cook		X	X	X
RML SPECIALTY HOSPITAL	5601 S COUNTY LINE RD	HINSDALE	IL	60521	Cook		X	X	X
ROCHELLE COMMUNITY HOSPITAL	900 N SECOND ST	ROCHELLE	IL	61068	Ogle		X	X	X
ROCKFORD VA	816 FEATHERSTONE RD	ROCKFORD	IL	61107	Winnebago			X	X
ROSELAND COMMUNITY HOSPITAL	45 W 111TH ST	CHICAGO	IL	60628	Cook				X
RUSH OAK PARK HOSPITAL	520 S MAPLE AVE	OAK PARK	IL	60304	Cook		X	X	X
RUSH UNIVERSITY MEDICAL CENTER	1653 W CONGRESS PKWY	CHICAGO	IL	60612	Cook		X	X	X
SAINT ANTHONY HOSPITAL	2875 W 19TH ST	CHICAGO	IL	60623	Cook		X	X	X
SAINT ANTHONY MEDICAL CENTER	5666 E STATE ST	ROCKFORD	IL	61108	Winnebago		X	X	X
SALEM TOWNSHIP HOSPITAL	1201 RICKER RD	SALEM	IL	62881	Marion		X	X	X
SARAH BUSH LINCOLN HEALTH CENTER	1000 HEALTH CENTER DR	MATTOON	IL	61938	Coles		X	X	X
SARAH D CULBERTSON MEMORIAL HOSPI	238 S CONGRESS ST	RUSHVILLE	IL	62681	Schuyler		X	X	X
SCHWAB REHABILITATION HOSPITAL	1401 S CALIFORNIA AVE	CHICAGO	IL	60608	Cook		X	X	X
SCOTT AIR FORCE BASE MEDICAL CTR	310 W LOSEY ST	SCOTT AFB	IL	62225	Saint Clair			X	
SELECT SPECIAL HOSP TOWN COUNTRY	3015 N BALLAS RD	SAINT LOUIS	MO	63131	St. Louis				
SELECT SPECIALTY HOSP ST LOUIS	300 1ST CAPITOL DR	SAINT CHARLES	MO	63301	St. Charles				
SHIRLEY RYAN ABILITY LAB	355 E ERIE ST	CHICAGO	IL	60611	Cook		X	X	X
SHRINERS HOSPITALS FOR CHILDREN	2211 N OAK PARK AVE	CHICAGO	IL	60707	Cook		X	X	X
SILVER CROSS HOSPITAL	1900 SILVER CROSS BLVD	NEW LENOX	IL	60451	Will	X	X	X	X
SOUTH BELOIT CLINIC	1969 W HART RD	BELOIT	WI	53511	Rock				X
SOUTH SHORE HOSPITAL	8012 S CRANDON AVE	CHICAGO	IL	60617	Cook				
SPARTA COMMUNITY HOSPITAL	818 E BROADWAY ST	SPARTA	IL	62286	Randolph		X	X	X

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SSM HEALTH GOOD SAMARITAN HOSPITA	1 GOOD SAMARITAN WAY	MOUNT VERNON	IL	62864	Jefferson			X	X
SSM HEALTH ST MARY'S HOSPITAL	400 N PLEASANT AVE	CENTRALIA	IL	62801	Marion			X	X
SSM HLTH CARDINAL GLENNON HOSP	1465 SOUTH GRAND BOULEVARD	SAINT LOUIS	MO	63104	St Louis city				
SSM HLTH DEPAUL HOSP ST LOUIS	12303 DE PAUL DR	BRIDGETON	MO	63044	St. Louis				
SSM HLTH REHAB HOSP BRIDGETON	12380 DE PAUL DR	BRIDGETON	MO	63044	St. Louis				
SSM HLTH REHAB HOSP RICHMOND HTS	1027 BELLEVUE AVE	RICHMOND HEIGHTS	MO	63117	St. Louis				
SSM HLTH ST CLARE HOSP FENTON	1015 BOWLES AVE	FENTON	MO	63026	St. Louis				
SSM HLTH ST JOSEPH HOSP ST CHARLE	300 1ST CAPITOL DR	SAINT CHARLES	MO	63301	St. Charles				
SSM HLTH ST JOSEPH HOSPITAL	500 MEDICAL PLAZA DRIVE	WENTZVILLE	MO	63385	St. Charles				
SSM HLTH ST LOUIS UNIVERSITY HOSP	1201 S GRAND BLVD	SAINT LOUIS	MO	63104	St Louis city				
SSM HLTH ST MARY'S HOSP ST LOUIS	6420 CLAYTON RD	RICHMOND HEIGHTS	MO	63117	St. Louis				
ST ALEXIUS BREAST CARE BARTLETT	1041 W STEARNS RD	BARTLETT	IL	60103	DuPage		X	X	X
ST ALEXIUS MEDICAL CENTER	1555 BARRINGTON RD	HOFFMAN ESTATES	IL	60169	Cook	X	X	X	X
ST ANTHONYS MEMORIAL HOSP	503 N MAPLE ST	EFFINGHAM	IL	62401	Effingham		X	X	X
ST BERNARD HOSPITAL	326 W 64TH ST	CHICAGO	IL	60621	Cook	X	X	X	X
ST CATHERINE HOSPITAL	4321 FIR ST	EAST CHICAGO	IN	46312	Lake	X			
ST ELIZABETH HOSPITAL CHICAGO	1431 N CLAREMONT AVE	CHICAGO	IL	60622	Cook		X	X	X
ST ELIZABETHS HOSPITAL	ONE ST ELIZABETHS BLVD	O FALLON	IL	62269	Saint Clair	X	X	X	X
ST FRANCIS HOSPITAL	1215 FRANCISCAN DR	LITCHFIELD	IL	62056	Montgomery		X	X	X
ST FRANCIS MEDICAL CENTER	211 ST FRANCIS DR	CAPE GIRARDEAU	MO	63703	Cape Girardeau				
ST JAMES HOSPITAL	2500 W REYNOLDS ST	PONTIAC	IL	61764	Livingston	X	X	X	X
ST JOHNS HOSPITAL	800 E CARPENTER ST	SPRINGFIELD	IL	62702	Sangamon				X
ST JOSEPH MEDICAL CENTER	2200 E WASHINGTON ST	BLOOMINGTON	IL	61701	McLean	X	X	X	X
ST JOSEPH MEMORIAL HOSPITAL	2 S HOSPITAL DR	MURPHYSBORO	IL	62966	Jackson		X	X	X
ST JOSEPHS HOSPITAL	12866 TROXLER AVE	HIGHLAND	IL	62249	Madison		X	X	X
ST JOSEPHS HOSPITAL BREESE	9515 HOLY CROSS LN	BREESE	IL	62230	Clinton		X	X	X
ST MARY MEDICAL CENTER	3333 N SEMINARY ST	GALESBURG	IL	61401	Knox		X	X	X
ST MARYS HOSPITAL	1800 E LAKE SHORE DR	DECATUR	IL	62521	Macon		X	X	X
ST VINCENT EVANSVILLE	3700 WASHINGTON AVE	EVANSVILLE	IN	47714	Vanderburgh				
ST VINCENT WARRICK	1116 MILLIS AVE	BOONVILLE	IN	47601	Warrick				
STREAMWOOD HOSPITAL	1400 E IRVING PARK RD	STREAMWOOD	IL	60107	Cook				X
SWEDISH AMERICAN HOSPITAL	1401 E STATE ST	ROCKFORD	IL	61104	Winnebago	X	X	X	X
SWEDISH AMERICAN MED CT BELVIDERE	1625 S STATE ST	BELVIDERE	IL	61008	Boone			X	X
SWEDISH COVENANT HOSPITAL	5145 N CALIFORNIA AVE	CHICAGO	IL	60625	Cook	X	X	X	X
TAYLORVILLE MEMORIAL HOSPITAL	201 E PLEASANT ST	TAYLORVILLE	IL	62568	Christian	X	X		X
THE QUAD CITIES REHAB INSTITUTE	653 52ND AVE	MOLINE	IL	61265	Rock Island		X	X	X
THOMAS H BOYD MEMORIAL HOSPITAL	800 SCHOOL ST	CARROLLTON	IL	62016	Greene		X	X	X
THOREK MEMORIAL HOSPITAL	850 W IRVING PARK RD	CHICAGO	IL	60613	Cook	X	X	X	X
THOREK MEMORIAL HOSPITAL	5025 N PAULINA ST	CHICAGO	IL	60640	Cook	X	X	X	X
TOUCHETTE REGIONAL HOSPITAL	5900 BOND AVE	CENTREVILLE	IL	62207	Saint Clair		X	X	X
TRINITY MEDICAL CENTER BETTENDORF	4500 UTICA RIDGE RD	BETTENDORF	IA	52722	Scott				
TRINITY REGIONAL HEALTH SYSTEM	2701 17TH ST	ROCK ISLAND	IL	61201	Rock Island		X	X	X
U OF IL HOSPITAL UI HEALTH	1740 W TAYLOR ST	CHICAGO	IL	60612	Cook	X	X	X	X
UCM ADVENTHEALTH BOLINGBROOK	500 REMINGTON BLVD	BOLINGBROOK	IL	60440	Will	X	X	X	X
UCM ADVENTHEALTH GLENOAKS	701 WINTHROP AVE	GLENDALE HEIGHTS	IL	60139	DuPage	X	X	X	X
UCM ADVENTHEALTH HINSDALE	120 N OAK ST	HINSDALE	IL	60521	DuPage	X	X	X	X
UCM ADVENTHEALTH LA GRANGE	5101 S WILLOW SPRINGS RD	LA GRANGE	IL	60525	Cook	X	X	X	X
UNION COUNTY HOSPITAL	517 N MAIN ST	ANNA	IL	62906	Union		X	X	X

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UNITY HEALTHCARE	1518 MULBERRY AVE	MUSCATINE	IA	52761	Muscatine				
UNITY POINT HEALTH TRINITY	500 JOHN DEERE RD	MOLINE	IL	61265	Rock Island		X	X	X
UNIVERSITY OF CHICAGO MEDICAL CEN	5841 S MARYLAND AVE	CHICAGO	IL	60637	Cook				X
VA CHICAGO HEALTH CARE SYSTEM	30 E 15TH ST	CHICAGO HEIGHTS	IL	60411	Cook			X	X
VA HEARTLAND EAST	2401 W MAIN ST	MARION	IL	62959	Williamson			X	X
VA MEDICAL CENTER	1900 E MAIN ST	DANVILLE	IL	61832	Vermilion			X	X
VALLEY WEST COMMUNITY HOSPITAL	1302 N MAIN ST	SANDWICH	IL	60548	DeKalb	X		X	X
VAN MATRE ENCOMPASS HLTH REHAB	950 S MULFORD RD	ROCKFORD	IL	61108	Winnebago		X	X	X
VETERANS AFFAIRS MEDICAL CENTER	3001 GREEN BAY RD	NORTH CHICAGO	IL	60064	Lake			X	X
VISTA MEDICAL CENTER EAST	1324 N SHERIDAN RD	WAUKEGAN	IL	60085	Lake	X	X	X	X
WABASH GENERAL HOSPITAL	1418 COLLEGE DR	MOUNT CARMEL	IL	62863	Wabash		X		X
WARNER HOSPITAL AND HEALTH SERV	422 W WHITE ST	CLINTON	IL	61727	DeWitt		X	X	X
WASHINGTON COUNTY HOSPITAL	705 S GRAND AVE	NASHVILLE	IL	62263	Washington		X	X	X
WEST SUBURBAN MEDICAL CENTER	3 ERIE CT	OAK PARK	IL	60302	Cook		X	X	X
WILLIAM S MIDDLETON MEMORIAL VET	2500 OVERLOOK TER	MADISON	WI	53705	Dane			X	X



**BlueCross BlueShield  
of Illinois**

Disruption Analysis Prepared for:  
Mokena School District #159

The match process results are shown below:

	IL-PPO	Blue Choice Options
Total Records	961	961
Total Matches	951	906
Percent Matched	98.96%	94.28%
Total Paid Amount	\$1,426,688	\$1,426,688
Total Paid Matches	\$1,406,586	\$1,127,136
Total Paid Percent Matched	98.59%	79.00%

**Disruption Analysis Disclaimer**

Blue Cross and Blue Shield identifies the results of the disruption analysis as having significance only when used as a relative measurement of our providers as compared with providers currently used by other medical plans. It can only be used to assure the client that we have a reasonable number of the current providers in the network(s).

The attached disruption/network analysis may not be 100% accurate, as the following variables may exist:

- No unique provider number/identifier exists across all networks. The extensiveness of the types of matches is dependent on the information in the file;
- A standard data format is not available across all networks;
- Matches to tax identification numbers may not necessarily indicate that the provider is in the network, if the provider bills under a Medical Group tax ID number rather than his/her individual tax identification number;
- We electronically match by tax identification number, NPI, and then by provider name and state, if provided. When resources and data elements are available, we manually check records that did not match after the initial computer analysis is completed. Differences in abbreviations and spelling, as well as other errors are potential areas for inaccuracies when matching individual provider records.

Because of the variables listed above, we do not guarantee that any of the declared matches or non-matches is absolutely accurate.

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Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association






The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsil.com/member/policy-forms/2025](http://www.bcbsil.com/member/policy-forms/2025) or by calling 1-800-541-2768. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Individual: Blue Choice \$500 PPO \$1,250 Out-of-Network \$2,500 Family: Blue Choice \$1,500 PPO \$3,750 Out-of-Network \$7,500	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>preventive care</u> services and services with a <u>copayment</u> and <u>prescription drugs</u> are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. ER \$400; Inpatient \$250/\$500/\$600; Outpatient Surgery Facility \$200/\$400/\$500. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Individual: Blue Choice \$1,250 PPO \$1,500 Out-of-Network \$4,500 Family: Blue Choice \$2,500 PPO \$4,500 Out-of-Network \$9,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-541-2768 for a list of Participating <u>Providers</u> .	You pay the least if you use a <u>provider</u> in Blue Choice <u>Network</u> . You pay more if you use a <u>provider</u> in PPO <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	\$45/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits: \$20/visit; <u>deductible</u> does not apply. See your benefit booklet* for more details.
	<u>Specialist</u> visit	\$50/visit; <u>deductible</u> does not apply	\$90/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Primary Care: \$25/visit Specialist: \$50/visit; <u>deductible</u> does not apply	Primary Care: \$45/visit Specialist: \$90/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.bcbsil.com/rx-drugs/drug-lists/drug-lists">www.bcbsil.com/rx-drugs/drug-lists/drug-lists</a>	Generic drugs (Preferred)	Retail: Preferred - \$5/prescription Non-Preferred - \$15/prescription Mail: \$15/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$5/prescription Non-Preferred - \$15/prescription Mail: \$15/prescription; <u>deductible</u> does not apply	Retail: \$15/prescription; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a
	Generic drugs (Non-Preferred)	Retail: Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail: \$45/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail: \$45/prescription; <u>deductible</u> does not apply	Retail: \$25/prescription; <u>deductible</u> does not apply	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called BCBSIL)

SBC IL Non-HMO LG-2025

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com/member/policy-forms/2025](http://www.bcbsil.com/member/policy-forms/2025)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Brand drugs (Preferred)	Retail: Preferred - \$45/prescription Non-Preferred - \$65/prescription Mail: \$135/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$45/prescription Non-Preferred - \$65/prescription Mail: \$135/prescription; <u>deductible</u> does not apply	Retail: \$65/prescription; <u>deductible</u> does not apply	50% additional charge after the applicable <u>copayment/coinsurance</u> . Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts. You may be eligible to synchronize your prescription refills, please see your benefit booklet* for details. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35, when obtained from a Preferred Participating or Participating Pharmacy.
	Brand drugs (Non-Preferred)	Retail: Preferred - \$85/prescription Non-Preferred - \$105/prescription Mail: \$255/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$85/prescription Non-Preferred - \$105/prescription Mail: \$255/prescription; <u>deductible</u> does not apply	Retail: \$105/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Preferred)	\$250/prescription; <u>deductible</u> does not apply	\$250/prescription; <u>deductible</u> does not apply	\$250/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Non-Preferred)	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200/visit plus 10% <u>coinsurance</u>	\$400/visit plus 30% <u>coinsurance</u>	\$500/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$400/visit plus 10% <u>coinsurance</u>	\$400/visit plus 10% <u>coinsurance</u>	\$400/visit plus 10% <u>coinsurance</u>	Per occurrence <u>deductible</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent Care</u>	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$1,000 or 50% of the eligible charge In-Network, \$500 Out-of-Network. See your benefit booklet* for details.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	\$45/office visit; <u>deductible</u> does not apply 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization required.
<b>If you are pregnant</b>	Office visits	Primary Care: \$25/initial visit Specialist: \$50/initial visit; <u>deductible</u> does not apply	Primary Care: \$45/initial visit Specialist: \$90/initial visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Habilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Skilled nursing care	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization may be required.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

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## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine eye care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)</li><li>• Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (1 per ear every 24 months)</li><li>• Infertility treatment (4 completed oocyte retrieval maximum, with special approval up to 6 per benefit period.)</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care (only in connection with diabetes)</li></ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768 or [www.bcbsil.com](http://www.bcbsil.com), U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit <http://insurance.illinois.gov>.

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-541-2768.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,310</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,200</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



**BlueCross BlueShield of Illinois**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

### Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>  
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

### To receive language or communication assistance free of charge, please call us at 855-710-6984.


Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لنلقى المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jil' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.





The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsil.com/member/policy-forms/2025](http://www.bcbsil.com/member/policy-forms/2025) or by calling 1-800-541-2768. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Individual: Blue Choice \$750 PPO \$1,750 Out-of-Network \$3,500 Family: Blue Choice \$2,250 PPO \$5,250 Out-of-Network \$10,500	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>preventive care</u> services and services with a <u>copayment</u> and <u>prescription drugs</u> are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. ER \$400; Inpatient \$250/\$500/\$600; Outpatient Surgery Facility \$200/\$400/\$500. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Individual: Blue Choice \$4,500 PPO \$6,100 Out-of-Network \$18,300 Family: Blue Choice \$9,000 PPO \$12,200 Out-of-Network \$36,600	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-541-2768 for a list of Participating <u>Providers</u> .	You pay the least if you use a <u>provider</u> in Blue Choice Network. You pay more if you use a <u>provider</u> in PPO Network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	\$55/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits: \$20/visit; <u>deductible</u> does not apply. See your benefit booklet* for more details.
	<u>Specialist</u> visit	\$50/visit; <u>deductible</u> does not apply	\$110/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Primary Care: \$25/visit Specialist: \$50/visit; <u>deductible</u> does not apply	Primary Care: \$55/visit Specialist: \$110/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.bcbsil.com/rx-drugs/drug-lists/drug-lists">www.bcbsil.com/rx-drugs/drug-lists/drug-lists</a>	Generic drugs (Preferred)	Retail: Preferred - \$5/prescription Non-Preferred - \$15/prescription Mail: \$15/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$5/prescription Non-Preferred - \$15/prescription Mail: \$15/prescription; <u>deductible</u> does not apply	Retail: \$15/prescription; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a
	Generic drugs (Non-Preferred)	Retail: Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail: \$45/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail: \$45/prescription; <u>deductible</u> does not apply	Retail: \$25/prescription; <u>deductible</u> does not apply	

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SBC IL Non-HMO LG-2025

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Brand drugs (Preferred)	Retail: Preferred - \$45/prescription Non-Preferred - \$65/prescription Mail: \$135/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$45/prescription Non-Preferred - \$65/prescription Mail: \$135/prescription; <u>deductible</u> does not apply	Retail: \$65/prescription; <u>deductible</u> does not apply	50% additional charge after the applicable <u>copayment/coinsurance</u> . Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts. You may be eligible to synchronize your prescription refills, please see your benefit booklet* for details. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35, when obtained from a Preferred Participating or Participating Pharmacy.
	Brand drugs (Non-Preferred)	Retail: Preferred - \$85/prescription Non-Preferred - \$105/prescription Mail: \$255/prescription; <u>deductible</u> does not apply	Retail: Preferred - \$85/prescription Non-Preferred - \$105/prescription Mail: \$255/prescription; <u>deductible</u> does not apply	Retail: \$105/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Preferred)	\$250/prescription; <u>deductible</u> does not apply	\$250/prescription; <u>deductible</u> does not apply	\$250/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Non-Preferred)	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200/visit plus 10% <u>coinsurance</u>	\$400/visit plus 30% <u>coinsurance</u>	\$500/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$400/visit plus 10% <u>coinsurance</u>	\$400/visit plus 10% <u>coinsurance</u>	\$400/visit plus 10% <u>coinsurance</u>	Per occurrence <u>deductible</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent Care</u>	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$1,000 or 50% of the eligible charge In-Network, \$500 Out-of-Network. See your benefit booklet* for details.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	\$55/office visit; <u>deductible</u> does not apply 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization required.
<b>If you are pregnant</b>	Office visits	Primary Care: \$25/initial visit Specialist: \$50/initial visit; <u>deductible</u> does not apply	Primary Care: \$55/initial visit Specialist: \$110/initial visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Habilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	Skilled nursing care	\$250/visit plus 10% <u>coinsurance</u>	\$500/visit plus 30% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization may be required.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

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## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (1 per ear every 24 months)
- Infertility treatment (4 completed oocyte retrieval maximum, with special approval up to 6 per benefit period.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (only in connection with diabetes)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768 or [www.bcbsil.com](http://www.bcbsil.com), U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit <http://insurance.illinois.gov>.

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-541-2768.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,510</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,870</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) copay/coins	\$250+10%
■ Other coinsurance	10%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



**BlueCross BlueShield of Illinois**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

### Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>  
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

### To receive language or communication assistance free of charge, please call us at 855-710-6984.

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لنلقى المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jil' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.





Mokena School District # 159

Current/Renewal Dental Financial Analysis (MTA & MCSA Members)

(Including Employee Contributions)

July 1, 2025 Renewal Date

		Cigna		Cigna
		(7/1/24-6/30/25)		(7/1/25-6/30/26)
		Current Policy Year		Renewal Policy Year
		(2-Year RG)		(Under RG)
	3/25		3/25	
	Census Enrollment		Census Enrollment	
Employee Contributions				
DHMO		HMO A2009- DHMO Network		HMO A2009- DHMO Network
Employee Only	3	\$21.12	3	\$21.12 (N/C)
Employee + Spouse	2	\$38.77	2	\$38.77 (N/C)
Employee + Child(ren)	2	\$48.00	2	\$48.00 (N/C)
Family	2	\$70.31	2	\$70.31 (N/C)
Est. Monthly Premium		\$377.52		\$377.52
Est. Annual Premium	9	\$4,530.24	9	\$4,530.24 (N/C)
Est. Annual Increase (\$)				No Change
Est. Annual Increase (%)				(N/C)
PPO		PPO- Total DPPO Network		PPO- Total DPPO Network
Employee Only	84	\$45.75	84	\$45.75 (N/C)
Employee + Spouse	6	\$85.63	6	\$85.63 (N/C)
Employee + Child(ren)	26	\$92.85	26	\$92.85 (N/C)
Family	12	\$145.48	12	\$145.48 (N/C)
Est. Monthly Premium		\$8,516.64		\$8,516.64
Est. Annual Premium	128	\$102,199.68	128	\$102,199.68 (N/C)
Est. Annual Increase (\$)				No Change
Est. Annual Increase (%)				(N/C)
Est. Combined Monthly Premium		\$8,894.16		\$8,894.16
Est. Combined Annual Premium	137	\$106,729.92	137	\$106,729.92
Est. Annual Increase (\$)				No Change
Est. Annual Increase (%)				(N/C)
Rate Guarantee		7/1/2026		7/1/2026
Employee Contributions				
DHMO Plan				
		Certified & Classified (10 & 12 months)		Certified & Classified (10 & 12 months)
Employee Only	1	\$0.00 (0.0%)	1	\$0.00 (0.0%)
Employee + Spouse	2	\$0.00 (0.0%)	2	\$0.00 (0.0%)
Employee + Child(ren)	2	\$6.33 (13.2%)	2	\$6.33 (13.2%)
Family	2	\$28.64 (40.7%)	2	\$28.64 (40.7%)
Est. Monthly Employee Contributions		\$69.94		\$69.94
Est. Annual Employee Contributions	7	\$839.28	7	\$839.28
		Classified (9 months)		Classified (9 months)
Employee Only	2	\$21.12 (100.0%)	2	\$21.12 (100.0%)
Employee + Spouse	0	\$38.77 (100.0%)	0	\$38.77 (100.0%)
Employee + Child(ren)	0	\$48.00 (100.0%)	0	\$48.00 (100.0%)
Family	0	\$70.31 (100.0%)	0	\$70.31 (100.0%)
Est. Monthly Employee Contributions		\$42.24		\$42.24
Est. Annual Employee Contributions	2	\$506.88	2	\$506.88
Est. Combined Monthly Employee Contributions		\$112.18		\$112.18
Est. Combined Annual Employee Contributions	9	\$1,346.16 (29.7%)	9	\$1,346.16 (29.7%)
PPO Plan				
		Certified & Classified (10 & 12 months)		Certified & Classified (10 & 12 months)
Employee Only	65	\$4.08 (8.9%)	65	\$4.08 (8.9%)
Employee + Spouse	5	\$43.96 (51.3%)	5	\$43.96 (51.3%)
Employee + Child(ren)	26	\$51.18 (55.1%)	26	\$51.18 (55.1%)
Family	12	\$103.81 (71.4%)	12	\$103.81 (71.4%)
Est. Monthly Employee Contributions		\$3,061.40		\$3,061.40
Est. Annual Employee Contributions	108	\$36,736.80	108	\$36,736.80
		Classified (9 months)		Classified (9 months)
Employee Only	19	\$45.75 (100.0%)	19	\$45.75 (100.0%)
Employee + Spouse	1	\$85.63 (100.0%)	1	\$85.63 (100.0%)
Employee + Child(ren)	0	\$92.85 (100.0%)	0	\$92.85 (100.0%)
Family	0	\$145.48 (100.0%)	0	\$145.48 (100.0%)
Est. Monthly Employee Contributions		\$954.88		\$954.88
Est. Annual Employee Contributions	20	\$11,458.56	20	\$11,458.56
Est. Combined Monthly Employee Contributions		\$4,016.28		\$4,016.28
Est. Combined Annual Employee Contributions	128	\$48,195.36 (47.2%)	128	\$48,195.36 (47.2%)
Est. Combined Monthly Employee Contributions		\$4,128.46		\$4,128.46
Est. Combined Annual Employee Contributions	137	\$49,541.52 (46.4%)	137	\$49,541.52 (46.4%)
Est. Annual Net Cost to				
Mokena School District #159	137	\$57,188.40	137	\$57,188.40
Est. Annual Increase (\$)				No Change
Est. Annual Increase (%)				(N/C)

## Mokena School District #159

### Current/Renewal Benefits Summary

July 1, 2025 Renewal Date

	Cigna Network / Non-Network Current/Renewal
<b>Plan:</b> <b>Usual &amp; Customary:</b> Level Source <b>Deductible</b> Employee Only Family <b>Deductible Applies to:</b> <b>Calendar Year Maximum</b>	<b>PPO Plan</b>  90th Percentile Fair Health  \$25 \$75 Basic & Major Services \$1,000
<b>Maximum Rollover:</b>  Progression Start Year 1 Progression Year 2 Progression Year 3 Progression Year 4 Total Annual Maximum + Account Limit	Progression Maximum Included- \$250/Calendar Year <i>(Class 1 Service must be completed every Calendar Year)</i>  Year 1: \$1,000 Year 2: \$1,250 Year 3: \$1,500 Year 4: \$1,750  <i>(The CY Cap will remain at the approved level as long as the member completes the Class 1 service/calendar year until they hit the Maximum of \$1,750)</i>
<b>COINSURANCE PERCENTAGE</b>  <b>Diagnostic &amp; Preventive Services</b> Oral Examinations Prophylaxis* X-Rays  Topical Fluoride Sealants Space Maintainers Emergency Palliative Treatment	 <b>100% / 100%</b> 2 per cal. Year 2 per cal. Year combined* Bitewings - 2 per calendar year Panorex - 1 every 3 cal. Years Full Mouth - 1 every 3 cal. Years One per calendar year - up to age 19 Up to age 16 Up to age 19
<b>Basic Services</b> Periodontal Cleanings* Fillings (Amalgam) Posterior Composites Simple Extractions Surgical Extractions Oral Surgery Periodontics (Non-Surgical) Periodontics (Surgical) Endodontics General Anesthesia	 <b>80% / 80%</b> 2 per cal. Year combined*
<b>Major Services</b> Crowns Inlays & Onlays Bridges Dentures Prosthodontics Implants	 <b>50% / 50%</b>
<b>Orthodontia Maximum</b>  <b>Waiting Periods for Timely Entrants</b> Initial Enrollment with New Carrier Annual Enrollment	 \$1,000 Lifetime Maximum Children to age 19 <b>50% / 50%</b>  <b>Annual Enrollment</b> No Waiting Periods No Waiting Periods

\*No more than 2 cleanings per year combined with prophylaxis and periodontal cleanings

## Mokena School District #159

### Current/Renewal/(Alternate Option) Voluntary Vision Financial Analysis

(Benefit Differences are Indicated in Green)

July 1, 2025 Renewal Date

VSP (Signature Network)	VSP (Signature Network)	VSP (Alternate Choice Plan)
7/1/24-6/30/25 <i>Current Policy Year</i>	7/1/25-6/30/26 <i>Renewal Policy Year</i> <i>Original Renewal- 7.1%</i> <i>Revised Renewal- 4%</i>	7/1/25-6/30/26 <i>Alternate Plan Design</i> <i>1. Change to Choice Network</i> <i>2. Fram Allowance from \$130 to \$200</i>

#### Frequency:

Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	12 Months	12 Months	12 Months

#### Copays:

Exam	\$10 Copay	\$10 Copay	\$10 Copay
Hardware	\$25 Copay	\$25 Copay	\$25 Copay

#### Allowances:

Contact Lens	Up to \$130	Up to \$130	Up to \$130
Frames	Up to \$130	Up to \$130	Up to \$200

3/25 Enrollment				
Employee Only	57	\$10.85	\$11.28 (+4.0%)	\$10.42 (-4.0%)
Employee + Spouse	11	\$17.36	\$18.06 (+4.0%)	\$16.66 (-4.0%)
Employee + Child(ren)	18	\$17.73	\$18.44 (+4.0%)	\$17.01 (-4.1%)
Family	20	\$28.58	\$29.72 (+4.0%)	\$27.43 (-4.0%)
Est. Monthly Premium		\$1,700.15	\$1,767.94	\$1,631.98
Est. Annual Premium	106	\$20,401.80	\$21,215.28	\$19,583.76

<b>Est. Annual Increase (\$)</b>	<b>\$813.48</b>	<b>(\$818.04)</b>
<b>Est. Annual Increase (%)</b>	<b>(+4.0%)</b>	<b>(-4.0%)</b>

<b>Rate Guarantee</b>	<b>Until 7/1/2025</b>	<b>Until 7/1/2027</b>	<b>Until 7/1/2027</b>
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**Mokena School District #159**  
**Current/Renewal Vision Plan Designs**  
**(Benefit Differences are Indicated in Green)**  
**July 1, 2025 Renewal Date**

	VSP (Signature Network)/ (Alternate Choice Network) Current/Renewal/Alternate Renewal Policy Year	
	Network	Non-Network
<b>Exam:</b> Exam by Ophthalmologist Exam by Optometrist Standard Contact Lens Fitting Exam Specialty Contact Lens Fitting Exam <i>(Applies to new contact lens wearers and/or a member who wears toric, gas permeable or multi-focal lenses)</i>	\$10 copay \$10 copay Up to \$60 copay Up to \$60 copay	Up to \$50 (\$45) Up to \$50 (\$45) included in allowance included in allowance
<b>Lenses (Standard) Per Pair:</b>  Single Vision Bifocal Trifocal Lenticular Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses Tints/Photochromic Adaptive Lenses  Scratch Resistant Coating Anti-Reflective	<i>All Lens Options are covered in full w/Copay, saving our members an average of 35-40%</i>  \$25 copay \$25 copay \$25 copay \$25 copay \$25 copay \$80-\$90 copay after \$25 copay \$120-\$160 copay after \$25 copay \$25 copay  \$15 copay after \$25 copay \$39 copay after \$25 copay	<i>The most popular Lens Options are covered in full w/Copay, saving our members an average of 20-25%</i>  Up to \$50 (\$30) Up to \$75 (\$50) Up to \$100 (\$65) Up to \$75 (\$100) Up to \$75 (\$50) Not Covered Not Covered Up to \$5  Not Covered Not Covered
<b>Contact Lenses*:</b> Medically Necessary (per pair) Cosmetic (Elective)	\$10 copay Up to \$130	Up to \$210 Up to \$105
<b>Frames:</b>	Signature- Up to \$130 Choice- Up to \$200	Up to \$70

\* In lieu of eyeglasses and frame benefit.

## Mokena School District #159

### Current/Renewal Vision Provider Network Comparison

VSP Stated there is no Change in Network Providers	
	VSP (VSP Signature Network) & (VSP Choice Network) Current/Renewal/Alternate
<b>Network Retail Stores/ Chains</b> <i>(A full directory will be listed on the website)</i>	<b>Participating:</b> Independent Providers Eyeconic Website Visionworks
<b>Optical Laboratory Model</b>	Provider can use the lab of their choice
<b>Percentage Network: Retail Stores/Chains Independent Providers</b>	Eyeconic and Visionworks Only 100%
<b>Number of Providers Nationally:</b> <i>(Includes Optometrists &amp; Ophthalmologists)</i>	22,505
<b>Number of Providers in Illinois:</b> <i>(Includes Optometrists &amp; Ophthalmologists)</i>	1,442

\*It is always best to verify the independent provider or retail location a member is visiting is part of the vision network and the types of services provided at that location (full service, eye exams only or dispense glasses/contacts only). For example, Costco and Pearle Vision don't offer exams at all the locations.