*2017 Plan Cost Comparison

The following health insurance plans are available to non-Medicare eligible participants. If you have Medicare Part A and Part B due to end stage renal disease, these plans are available to you within the 30-month coordination period.

This comparison is to be used as a guide. In case this summary differs from the health plan text or any health plan term or condition, the official contract document must govern.

While every effort has been made to ensure up-to-date information, CTPF is not responsible for the final adjudication of insurance claims, which are solely the responsibility of the health plan. *(See page 5 for CTPF Plan rate information.)*

Blue Cross & Blue Shield PPO	UnitedHealthcare Choice Plus PPO	Blue Cross & Blue Shield HMO Illinois
CTPF retiree/survivor cost for single coverage monthly premium cost with CTPF premium subsidy*		
$783.39	$701.09	$500.71
CTPF retiree/survivor + 1 dependent monthly premium cost with CTPF premium subsidy*		
$2,350.17	$2,103.26	$1,502.12
CTPF retiree/survivor + 2 or more dependents monthly premium cost with CTPF premium subsidy*		
$3,916.95	$3,505.43	$2,503.53
CTPF dependent cost for single coverage^ (dependents do not receive the CTPF premium subsidy)		
$1,566.78	$1,402.17	$1,001.41

* The retiree/survivor cost is the amount paid for monthly coverage after CTPF applies the health insurance premium subsidy. The current subsidy is 50% of total premium cost. See *page 13* for more information.

^ This is the amount a dependent pays for single coverage in special circumstances when only one family member is Medicare eligible. See *page 42* for additional information about this situation.

Plan Comparison: Non-Medicare Eligible Members

Blue Cross and Blue Shield PPO

NETWORK NAME

Participating Provider Organization (PPO)

PLAN FEATURES

Traditional PPO. You may use any physician. Plan typically pays 80% PPO and 50% Non-PPO of allowed charges after the plan year deductible has been met.

CONTACT INFORMATION

Group number: P06675
1-800-331-8032 Customer Service
1-800-851-7498 Mental Health
1-800-423-1973 Pharmacy
1-800-299-0274 Nurse Line
www.bcbsil.com

HOW TO ENROLL

Complete CTPF Form 350 *(available in the center of this book or online)*. Return with required documentation to CTPF.

SERVICE AREA

Nationwide

FOREIGN TRAVEL

Foreign travel emergency benefits available. Other foreign medical coverage may be available, contact BCBS at 1-800-810-2583 for more information.

PHYSICIAN SELECTION

Enhanced benefit level when you use a PPO hospital or physician.

LIFETIME MAXIMUM

No lifetime maximum

OUT-OF-POCKET MAXIMUMS

Individual:	$2,400	PPO
	$4,800	Non-PPO
Family:	$4,000	PPO
	$9,600	Non-PPO

Prescription copays do not apply towards plan deductible.

UnitedHealthcare Choice Plus PPO

NETWORK NAME

United Healthcare Choice Plus

PLAN FEATURES

Traditional PPO. You may use any physician. Plan typically pays 80% PPO and 60% Non-PPO of allowed charges after the plan year deductible has been met. Some services are available for a copayment.

CONTACT INFORMATION

Group number: 717511
1-866-633-2446 Customer Service
1-866-633-2446 Mental Health
1-888-887-4114 Nurse Line
www.myuhc.com

HOW TO ENROLL

Complete CTPF Form 350 *(available in the center of this book or online)*. Return with required documentation to CTPF.

SERVICE AREA

Nationwide

FOREIGN TRAVEL

Foreign travel emergency benefits available.

PHYSICIAN SELECTION

Enhanced benefit level when you use a PPO hospital or physician.

LIFETIME MAXIMUM

No lifetime maximum

OUT-OF-POCKET MAXIMUMS

Individual:	$4,500	PPO
	$11,000	Non-PPO
Family:	$9,000	PPO
	$22,000	Non-PPO

Prescription copays apply towards out-of-pocket maximums.

Blue Cross and Blue Shield HMO Illinois (HMOI)

NETWORK NAME

HMO Illinois (HMO)

PLAN FEATURES

Traditional HMO. You must select an HMOI primary care physician (PCP). Referral required for specialty care. Plan typically pays 100% after copayment. Must use network provider.

CONTACT INFORMATION

Group number: H64047
1-800-892-2803 Customer Service
1-800-423-1973 Pharmacy
1-800-299-0274 Nurse Line
www.bcbsil.com

HOW TO ENROLL

Complete CTPF Form 350 *(available in the center of this book or online)*. Return with required documentation to CTPF.

SERVICE AREA

Chicago vicinity only

FOREIGN TRAVEL

Foreign travel emergency benefits available.

PHYSICIAN SELECTION

PCP directed, referrals required.
Must use network provider.

LIFETIME MAXIMUM

No lifetime maximum

OUT-OF-POCKET MAXIMUMS

Individual:	$1,500
Family:	$3,000

Prescription copays, vision, durable medical equipment, and prosthetics do not apply to out-of-pocket maximums.

Plan Comparison: Non-Medicare Eligible Members

Blue Cross and Blue Shield PPO	
ANNUAL PLAN YEAR DEDUCTIBLE	
$500	PPO
$1,000	Non-PPO
ADDITIONAL DEDUCTIBLES	
$200	Deductible each PPO hospital admission *(not to exceed 2 copays per year)*
$400	Deductible each non-PPO hospital admission *(not to exceed 2 copays per year)*
$150	Deductible each emergency room visit, unless admitted
HOSPITAL SERVICES	
Inpatient	
80%	PPO hospital plus $200 hospital admission deductible
50%	Non-PPO hospital plus $400 hospital admission deductible
Skilled Nursing Facility *(non-custodial)*	
80%	PPO facility plus $200 hospital admission deductible
50%	Non-PPO facility plus $400 hospital admission deductible
Services must be rendered in a BCBS-approved skilled nursing facility.	
OUTPATIENT SERVICES	
Chemotherapy, Radiation Therapy	
80%	PPO provider
50%	Non-PPO provider
Emergency Room	
100%	After $150 emergency room deductible, unless admitted
Lab/X-ray	
80%	PPO provider
50%	Non-PPO provider
Speech, Physical and Occupational Therapy	
80%	PPO provider
50%	Non-PPO provider
Surgery	
80%	PPO provider
50%	Non-PPO provider
Urgent Care	
80%	PPO provider
50%	Non-PPO provider

UnitedHealthcare Choice Plus PPO

ANNUAL PLAN YEAR DEDUCTIBLE

Individual: $1,000 PPO
$3,000 Non-PPO
Family: $2,000 PPO
$6,000 Non-PPO
Deductible does not apply to all services.

ADDITIONAL DEDUCTIBLES

None

HOSPITAL SERVICES

Inpatient
100% PPO after $200 per admission copay
60% Non-PPO after deductible, prior authorization required

Skilled Nursing Facility *(non-custodial)*
80% PPO after deductible
60% Non-PPO after deductible
Limited to 60 days per year

OUTPATIENT SERVICES

Chemotherapy, Radiation Therapy
80% PPO after deductible
60% Non-PPO after deductible

Emergency Room
$150 Copay PPO and non-PPO providers

Lab/X-ray
No copay PPO provider, deductible does not apply
60% Non-PPO provider, after deductible

Speech, Physical and Occupational Therapy
$30 Copay PPO provider, deductible does not apply
60% Non-PPO provider, after deductible
Limited to 20 visits per year per therapy.

Surgery
80% PPO after deductible
60% Non-PPO after deductible

Urgent Care
$75 Copay PPO, deductible does not apply
60% Non-PPO, after deductible

Blue Cross and Blue Shield HMO Illinois (HMOI)

ANNUAL PLAN YEAR DEDUCTIBLE

None

ADDITIONAL DEDUCTIBLES

None

HOSPITAL SERVICES

Inpatient
$200 Copay per admission, *(not to exceed 2 copays per year)*

Skilled Nursing Facility *(non-custodial)*
No copay

OUTPATIENT SERVICES

Chemotherapy, Radiation Therapy
$30 Copay

Emergency Room
$125 Copay: PCP notification recommended except in life threatening situation

Lab/X-ray
$30 Copay

Speech, Physical and Occupational Therapy
No copay
Limited to 60 visits per year per therapy

Surgery
$175 Copay

Urgent Care
$30 Copay

Plan Comparison: Non-Medicare Eligible Members

Blue Cross and Blue Shield PPO
PROFESSIONAL AND OTHER SERVICES
Allergy Shots 80% PPO provider 50% Non-PPO provider
Ambulance 80%
Chiropractic Visits 80% PPO provider 50% Non-PPO provider Limited to 40 visits per year.
Dental Accidental care only: coverage provided for repair of accidental injury to sound natural teeth
Eyeglasses and Contacts Not covered Contact BCBS customer service at 800-331-8032 for details on the vision discount program.
Maternity 80% PPO provider 50% Non-PPO provider
Physician Office Visits 80% PPO provider 50% Non-PPO provider
Preventive Care Services *(physicals, diagnostic tests, immunizations)* 100% of allowed charges PPO and 50% non-PPO providers Includes routine physical examinations, diagnostic tests, and immunizations
Prosthetic Devices and Medical Equipment 80% up to purchase price
Vision Screening and Exams Not covered Contact BCBS customer service at 800-331-8032 for details on the vision discount program.

UnitedHealthcare Choice Plus PPO

PROFESSIONAL AND OTHER SERVICES

Allergy Shots
No charge
Physician visit copay applies

Ambulance
80% PPO/Non-PPO after deductible
Prior authorization required for non-emergency

Chiropractic Visits
$30 Copay PPO, deductible does not apply
60% Non-PPO after deductible
Limited to 20 visits per year.

Dental
80% PPO/Non-PPO after deductible
Accident only; Prior authorization required

Eyeglasses and Contacts
Discounts on frames, lenses, and lens options

Maternity
See applicable service for benefit level. Copay only applies to initial office visit for physician office services

Physician Office Visits
$30 Copay PPO provider, deductible does not apply
$50 Copay PPO specialist provider, deductible does not apply
60% Non-PPO provider after deductible

Preventive Care Services *(physicals, diagnostic tests, immunizations)*
100% PPO for routine lab, x-rays, mammograms, preventive tests PPO preventive care not subject to deductible
60% Non-PPO after deductible

Prosthetic Devices and Medical Equipment
80% PPO after deductible
60% Non-PPO after deductible
Limited to single purchase of each type of device every 3 years.

Vision Screening and Exams
Not covered

Blue Cross and Blue Shield HMO Illinois (HMOI)

PROFESSIONAL AND OTHER SERVICES

Allergy Shots
$30 Copay

Ambulance
No copay

Chiropractic Visits
$30 Copay
Limited to 40 visits per year.

Dental
Accidental care only: coverage provided for repair of accidental injury to sound natural teeth

Eyeglasses and Contacts
Covered up to $75 allowance every 24 months
Contact BCBS customer service at 800-331-8032 for details on the vision discount program.

Maternity
100% after $30 copay

Physician Office Visits
$30 Copay

Preventive Care Services *(physicals, diagnostic tests, immunizations)*
No copay

Prosthetic Devices and Medical Equipment
No copay

Vision Screening and Exams
$30 Copay
Limited to one screening/exam every 12 months

Plan Comparison: Non-Medicare Eligible Members

Blue Cross and Blue Shield PPO
BEHAVIORAL HEALTH SERVICES
Inpatient 80% PPO hospital plus $200 hospital admission deductible 50% Non-PPO hospital plus $400 hospital admission deductible
Outpatient 80% PPO provider 50% Non-PPO provider
PRESCRIPTION DRUG BENEFITS*
Mail Order 90-Day Supply $20 Generic copay $60 Formulary brand copay $100 Non-formulary brand copay
Retail 30-Day Supply $10 Generic copay $30 Formulary brand copay $50 Non-formulary brand copay
Retail 90-Day Supply $25 Generic copay $75 Formulary brand copay $125 Non-formulary brand copay

*** Specialty medications limited to a 30-day supply**

UnitedHealthcare Choice Plus PPO

BEHAVIORAL HEALTH SERVICES

Inpatient

100% PPO after $200 copay
60% Non-PPO after deductible

Outpatient

100% PPO, deductible does not apply
60% Non-PPO provider after deductible

PRESCRIPTION DRUG BENEFITS*

Mail Order 90-Day Supply

$17.50 Tier 1 copay
$75.00 Tier 2 copay
$125.00 Tier 3 copay

Retail 30-Day Supply

$7.00 Tier 1 copay
$30.00 Tier 2 copay
$50.00 Tier 3 copay

Retail 90-Day Supply

Not offered

*** Specialty medications limited to a 31-day supply**

Blue Cross and Blue Shield HMO Illinois (HMOI)

BEHAVIORAL HEALTH SERVICES

Inpatient

$200 deductible each hospital admission *(not to exceed 2 copays per year)*

Outpatient

$30 Copay
All care coordinated through your PCP

PRESCRIPTION DRUG BENEFITS*

Mail Order 90-Day Supply

$20 Generic copay
$60 Formulary brand copay
$100 Non-formulary brand copay

Retail 30-Day Supply

$10 Generic copay
$30 Formulary brand copay
$50 Non-formulary brand copay

Retail 90-Day Supply

$25 Generic copay
$75 Formulary Brand copay
$125 Non-formulary brand copay

*** Specialty medications limited to a 30-day supply**

INFO

*** Prescription Drug Plan Changes**

Each health insurance plan utilizes a formulary (a list of preferred prescription drugs). Formularies may change annually, so make sure you review your plan's 2017 formulary to determine if your prescription expenses will change.

*** BCBS Non-Med PPO Pharmacy Network Change**

Effective January 1, 2017, CVS-owned pharmacies, including CVS pharmacies in Target® stores, will no longer be a part of the Blue Cross and Blue Shield of Illinois pharmacy network.