# SCHEDULE OF BENEFITS – PLAN M6

**Effective January 1, 2023**

This plan uses the Blue Choice Select (BCS) PPO Network. (Members whose home residence is in Sangamon, Wabash, or Lawrence counties; or who reside outside the state of Illinois; or those working at Red Hill CUSD 10 or Wabash CUSD 348 will use the BCBS PPO Network. If you have questions regarding your network assignment, ask your district for assistance.) To receive maximum benefits, use Network providers. You may search online at **www.bcbsil.com** to determine if your provider belongs to the BCS Network. If you use a Non-Network provider your share of costs will be higher and you may be balance billed by the provider for amounts that exceed the plan's allowed amounts. You will also be responsible for pre-certifying your services when you use Non-Network providers.

Benefits are paid subject to the copays, deductibles, benefit percentages and maximum amounts shown below. If you have questions about your benefits, please contact BVA Customer Service at **(855) 686-8517.** BVA representatives are available to help you find quality PPO providers and help you understand your benefits and your share of the costs based on the plan's copays, deductibles, coinsurance, and out of pocket maximums.

| **Benefit Maximums** | | |
|---|---|---|
| Calendar Year Maximum Benefits | Chiropractic and Osteopathic Manipulation - $750 | |
| **Deductible and Out-of-Pocket Maximum** | **Network** | **Non-Network** |
| Calendar Year Deductible<br>• Individual<br>• Family | $400<br>$1,200 | $800<br>$2,400 |
| Calendar Year Out-of-Pocket*<br>• Individual<br>• Family | $1,200<br>$2,400 | $4,500<br>$9,000 |
| Network and Non-Network deductible and out-of-pocket amounts will accumulate separately. | | |
| Affordable Care Act (ACA) Cost Share Maximum**<br>• Individual<br>• Family | $2,500<br>$5,000 | N/A<br>N/A |

*** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**:

- All copayment amounts;
- Spinal adjustment (chiropractic and osteopathic manipulation) charges;
- Charges for surgical procedures for morbid obesity outside the Network;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of the Lifetime or Calendar Year Maximums.

****The following expenses will apply towards the ACA Cost Share Maximum:**

- Deductible and coinsurance that applies to the Network Out-of-Pocket Maximum;
- Network medical Copayments and all prescription drug copayment amounts.

| Description of Service | Network | Non-Network |
|---|---|---|
| **A Copayment applies for each Inpatient Hospital Admission and Outpatient Surgical Procedure performed at an Outpatient Hospital Facility or Ambulatory Surgical Facility. (Maximum of 3 such Copayments per person per calendar year)**<br>***All charges are subject to the Calendar Year Deductible unless otherwise noted.*** | | |
| Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse) | $250<br>then 90% | $550<br>then 70% |
| Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment) | $250<br>then 90% | $550<br>then 70% |
| The charges of certain providers will be considered at the same benefit level as the hospital facility in which services are rendered. This benefit applies only to the following inpatient or outpatient hospital facility charges:<br><br>(1) Inpatient hospital professional fees for radiology, pathology or anesthesiology;<br>(2) Outpatient hospital professional fees for radiology, pathology or anesthesiology. | | |
| Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation. | $300<br>then 85%,<br>no deductible | $300<br>then 85%,<br>no deductible |
| Non-Network Emergency Room treatment will be subject to the Network Out-of-Pocket Maximum. | | |
| Urgent Care Center/Facility<br>Facility Charge<br><br>Physician Charge | <br>$40 then 90%,<br>no deductible<br><br>90% | <br>$40 then 90%,<br>no deductible<br><br>90% |
| Medically Necessary Ambulance Transportation | 80% | 80% |
| Non-Network Medically Necessary Ambulance Expenses will be subject to the Network Out-of-Pocket Maximum. | | |
| Pre-admission Testing | 100%,<br>no deductible | 70%,<br>no deductible |
| Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits) | 90% | 70% |
| Second Surgical Opinion | 100%,<br>no deductible | 70%,<br>no deductible |
| Diagnostic Laboratory Expenses<br>(Other than Independent Lab)<br><br>Diagnostic Laboratory Expenses<br>(Independent Lab) | <br>90%<br><br>100%,<br>no deductible | <br>70%<br><br>70% |
| Diagnostic Laboratory Expenses - When a covered member uses the services of a Network Independent Lab provider there will be no out-of-pocket expense to the member and covered services will be covered at 100%. | | |
| Diagnostic Mammogram | 100%,<br>no deductible | 70% |
| Diagnostic X-ray Expenses | 90% | 70% |
| Organ and Tissue Transplants | 95%,<br>no deductible | Not Covered |
| Surgical Treatment of Morbid Obesity | 90% | 50% up to $50,000 |

| Description of Service | Network | Non-Network |
|---|---|---|
| ***All charges are subject to the Calendar Year Deductible unless otherwise noted.*** | | |
| Primary Doctor Office Visit or Retail Clinic Visit (Incl. general or family practice, internists, pediatricians, OB/GYN physicians and mental health providers) | $25 then 100%, no deductible | 70% |
| Specialist Physician Office Visit | $30 then 100%, no deductible | 70% |
| All services other than the Office Visit during the Primary Doctor or Specialist Office Visit | 90% | 70% |
| Chiropractic and Osteopathic Manipulation | 90% | 70% |
| Durable Medical Equipment | 90% | 70% |
| Hearing Aids or Devices and related services<br>- Children up to age 18 (limited to one hearing instrument for each ear every 36 months)<br>- Age 18 and older participants (limited to $2,500 per instrument for each ear every 24 months) | 90% | 70% |
| Physical, Speech or Occupational Therapy | 90% | 70% |
| Home Health Care<br>Home Infusion<br>Skilled Nursing Facility<br>Hospice Care | 90% | 70% |
| All Other Covered Expenses | 90% | 70% |

## PRESCRIPTION DRUG CARD BENEFIT

The prescription drug program is managed by Prime Therapeutics. You have the option to fill the first two months of a newly prescribed **Brand Name** maintenance medication at any Prime network retail pharmacy for the normal 30 day copay. After the first two fills, **Brand Name** maintenance medications are required to be filled through Home Delivery. You can fill any covered medication that is not a **Brand Name** maintenance or specialty medication at any Prime network retail pharmacy. **CVS pharmacies are not in the Prime pharmacy network.**

You are required to purchase specialty drugs that are self-administered through the network Specialty Pharmacy. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. In most cases specialty drugs are limited to a 30 day supply. **If you try to fill a specialty script at retail after your first fill, the pharmacy will notify you that the drug must be ordered from Accredo Specialty Pharmacy.** You can contact Accredo at **1 (833) 721-1619**. Any specialty drug administered in a physician's office, clinical or hospital setting will be covered under the plan's medical benefit.

| Prescription Drug Copayments | Retail 30 day supply | Home Delivery 90 day supply |
|---|---|---|
| **Generic** | $12 | $30 |
| **Preferred Brand** | $25 | $55 |
| **Non-Preferred** | $40 | $100 |
| **Oral & Injectable Specialty Drugs*** | Copay plus 3% to a maximum of $150 | n/a |
| ***First specialty fill may be at retail (if available), thereafter you MUST use the network Specialty Pharmacy. | | |

## WELLNESS BENEFIT

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRSA (the Guidelines), as described under Wellness / Preventive Services in the Covered Major Medical Expenses section of the Plan Document and Summary Plan Description and as outlined on the following page.

| Description of Wellness Service | Network | Non-Network |
|---|---|---|
| ***Charges are <u>not</u> subject to the Calendar Year Deductible except as noted.*** | | |
| Wellness Office Visits for Children (when recommended by Guidelines based on patient's age, gender or health risk factors) | 100% | 70%, after deductible |
| Wellness Office Visits for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors) | 100% | 70%, after deductible |
| Childhood Immunizations and Vaccinations per Guidelines | 100% | 70%, after deductible |
| Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine | 100% | 70%, after deductible |
| Flu vaccine | 100% | 100% up to $40 maximum |
| Pneumonia vaccine per Guidelines | 100% | 100% up to $85 maximum |
| Zoster (Zostavax) for Shingles per Guidelines | 100% | 100% up to $200 maximum |
| Tetanus, Diptheria Toxoids per Guidelines | 100% | 100% up to $40 maximum |
| Hepatitis A and B per Guidelines | 100% | 100% up to $100 maximum |
| Combined Tetanus, Diptheria and Pertussis (TDAP) per Guidelines | 100% | 100% up to $55 maximum |
| Routine Mammogram | 100% | 100% |
| Routine Pap Smear | 100% | 100% |
| Routine PSA Test | 100% | 100% |
| Routine Laboratory, X-ray and Screening Tests recommended by Guidelines. | 100% | 70%, after deductible |
| Routine Screening for Colorectal Cancer using fecal occult blood testing, Cologuard, sigmoidoscopy or colonoscopy (age 50 and over). Frequency as provided by Guidelines. | 100% | 70%, after deductible |
| Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors) | 100% | 70%, after deductible |

## Recommended Preventive Services

The following is a **partial list** of services that are covered by the Plan when specifically listed under the Wellness Benefit or when recommended for individuals of the patient's age, gender or health risk factors, in accordance with Guidelines published by the USPSTF, CDC or HRSA. An up-to-date list of the current Guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/

**For Children:**

- Well child exams
- Standard routine immunizations recommended by the Guidelines
- Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
- Gonorrhea preventive medication for eyes in at risk newborns
- Standard metabolic screening panel for inherited enzyme deficiency diseases
- Screening and counseling for obesity
- Evaluation for fluoride treatment and fluoride supplements
- Behavioral assessments
- Screening for autism (at 18 and 24 months)
- Vision screening
- Oral health assessment
- Developmental screening, autism screening and behavioral assessment
- Screening for lead and tuberculosis

**For Women:**

- Annual physical exam
- Annual screening mammogram
- Annual pap smears, screening for cervical cancer, HPV testing
- Evaluation, counseling and genetic testing for BRCA breast cancer gene and/or for chemoprevention for women at high risk for breast cancer due to family history or other factors
- Screening pregnant women for anemia, gestational diabetes, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
- Screening for gonorrhea, chlamydia, syphilis
- Counseling and equipment to promote and aid with breast feeding
- Folic acid supplements for pregnant women
- Screening for domestic and interpersonal violence
- Osteoporosis screening (age 60 or older)
- FDA approved contraceptive methods, sterilization procedures and counseling

A detailed listing of women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

**For Men:**

- Annual physical exam
- Annual PSA test/screening for prostate cancer
- Screening for abdominal aortic aneurysm (ages 65 – 75 with history of smoking)

**For Adolescents and Adults at Appropriate Ages or With Risk Factors:**

- Screening for elevated cholesterol and lipids, high blood pressure, diabetes
- Screening and counseling for certain sexually transmitted diseases and HIV
- Screening and counseling for hepatitis B and C
- Screening and counseling for alcohol abuse in a primary care setting
- Screening, counseling and interventions for tobacco use
- Screening and counseling for obesity, diet and nutrition
- Screening for depression in a primary care setting
- Screening for colorectal cancer (ages 50 – 75)
- Screening for lung cancer (ages 55 – 80 with history of smoking)
- Standard routine immunizations recommended by the Guidelines
- Aspirin to prevent cardiovascular disease (women ages 55 – 79; men ages 45 – 79)

In some cases the Guidelines specify how often the Plan must cover a service as a recommended preventive service when provided by a Network provider. In other cases, the Plan may impose reasonable frequency limits or may use reasonable medical management techniques to ensure that care is provided in an appropriate setting.