2022 HEALTH CARE PLAN SUMMARIES

BCBS PPO Plus Hawaii

Plan Code: M80

Basic Plan Information			
Plan Type	PPO	Member Service	(877) 238-5951
Is a PCP Required?	No	Web Address	www.bcbsil.com/abbvie
Group Number	778089	Provider Network	PPO

	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Preventive Care Benefits**		
Annual Physical Exams for Adults	100% coverage; ded. does not apply; annual physical exam adults age 18+ incl. all related blood and urine laboratory testing performed as part of the annual exam and determined necessary by the patient's doctor	70% coverage after deductible
Annual Immunizations for Adults	100% coverage; ded. does not apply; adults age 18+ for adult immunizations as defined by the CDC and U.S. Preventive Services task force (excludes immunizations for travel)	70% coverage after deductible
Annual Screenings for Adults	100% coverage; ded. does not apply; adults age 18+ for recommended screenings as part of the annual physical exam incl.: hearing, vision, cholesterol, hypertension, diabetes, skin cancer, discussion of overall health and lifestyle	70% coverage after deductible
Annual Colorectal Screenings for Adults	100% coverage; ded. does not apply; adults age 40+ for colorectal cancer screening incl.: fecal occult blood test, flexible sigmoidoscopy, colonoscopy	70% coverage after deductible
Annual Bone Density Screenings for Adults	100% coverage; ded. does not apply; adults age 50+	70% coverage after deductible
Annual PSA Screening	100% coverage; ded. does not apply; adult males age 40+	70% coverage after deductible
Annual Well Woman Exam	100% coverage; ded. does not apply; for annual well woman exam (in addition to annual physical exam) incl. pap smear (ages 18+) and mammogram (age 35+)	70% coverage after deductible
Well Child Visits Under Age 2	100% coverage; ded. does not apply; at least 12 well child (preventive) visits are covered without a deductible for children under age 6	100% coverage; at least 12 well child (preventive) visits are covered without a deductible for children under age 6
Well Child Visits Over Age 2	100% coverage; ded. does not apply; At least 12 well child (preventive) visits are covered without a deductible for children under age 6**	100% coverage; at least 12 well child (preventive) visits are covered without a deductible for children under age 6**
Childhood Immunizations	100% coverage; ded. does not apply; all recommended childhood immunizations, incl. HPV vaccine (excludes immunizations for travel)	70% coverage after deductible
Childhood Screenings	100% coverage; ded. does not apply; recommended screenings as part of the annual exam incl. health and developmental history, hearing, vision and skin screening	70% coverage after deductible

Notes:

* Benefits are based on reasonable charges.

** Network benefits for these services at ages younger than listed or outside of the schedule shown are paid at 80% after deductible.

These benefits do not apply to individuals employed outside of the US or in Puerto Rico, except for certain designated transferred employees. Each program has its own eligibility requirements. See your Employee Benefits Handbook for details. AbbVie reserves the right to change or end its benefit plans or programs at any time. This document is not a full summary of the plans or policies or a description of their key features or details. In case of any conflict or question, the official plan documents or applicable policies, as amended from time to time, will govern.

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	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Annual Deductible	$100 per person; $250 per family (in and out-of-network combined)	$300 per person; $900 per family (in and out-of-network combined)
Out-of-Pocket Maximum	$3,000 per person; $9,000 per family (in and out-of-network combined)	$3,000 per person; $9,000 per family (in and out-of-network combined)
Lifetime Maximum	None	None
Inpatient Benefits	*Prenotification required; $250 penalty applies for failure to prenotify (to max. $1,000 penalty per person per year)*	
Hospital Services	80% coverage after deductible	70% coverage after deductible
Maternity (newborn and delivery)	80% coverage after deductible; separate deductibles may apply to mother and baby	70% coverage after deductible; separate deductibles may apply to mother and baby
In-Hospital Physicians and Surgeons	80% coverage after deductible	70% coverage after deductible
Outpatient Benefits		
Ambulatory Surgery	80% coverage after deductible**	70% coverage after deductible**
Ambulance	80% coverage; deductible does not apply	80% coverage; deductible does not apply
Emergency Room	$150 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 80% after deductible	$150 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 70% after deductible
Urgent Care	$35 copayment per visit*	$35 copayment per visit***
Diagnostic X-Ray and Lab	80% coverage after deductible	70% coverage after deductible
Office Visits	$20 copayment per visit; excludes x-ray/lab***	70% coverage after deductible
Physician and Professional Services		
Maternity Physician Charges (delivery, prenatal, and first postnatal visit)	$20 copayment for first OB visit, then 80% coverage after deductible	70% coverage after deductible**
Maternity Prenatal Care Screening and Lactation Support	100% coverage for screening recommended by Affordable Care Act, lactation counseling and renting breast feeding equipment**	70% coverage after deductible**

Notes:

* Benefits are based on reasonable charges.

** Some procedures require prenotification; some limits may apply.

***All copayments apply to the Annual Deductible and Out-of-Pocket Maximums.

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Mental Health Benefits	*Must precertify inpatient services through Optum Behavioral Health: (855) 809-2013; prenotification is required for all autism, biofeedback, electroshock therapy, hypnosis and psychological testing*	
Inpatient Services	80% coverage after deductible	80% coverage after deductible; a $250 penalty applies for failure to precertify
Outpatient Services	$20 copayment per visit	80% coverage after deductible
Substance Abuse Benefits	*Must precertify inpatient services through Optum Behavioral Health: (855) 809-2013; prenotification is required for all autism, biofeedback, electroshock therapy, hypnosis and psychological testing*	
Inpatient Services	80% coverage after deductible	80% coverage after deductible; a $250 penalty applies for failure to precertify
Outpatient Services	$20 copayment per visit	80% coverage after deductible
Other Benefits		
Chiropractic Services	$20 copayment per visit; $1,000 benefit max. per calendar year combined in/out- of-network***	Refer to in-network benefits
Physical Therapy	80% coverage after deductible	70% coverage after deductible
Home Health Care	80% coverage after deductible; 60 visits per calendar year combined in/out-of-network**	70% coverage after deductible; 60 visits per calendar year combined in/out-of-network**
Durable Medical Equipment	80% coverage after deductible**	70% coverage after deductible**
Hospice Care	80% coverage after deductible**	70% coverage after deductible**
Vision Benefits	$25 copayment for one routine exam per calendar year; eyewear not covered; hardware discounts are available on the Blue365 discount program; combined in/out-of-network benefit	
Podiatrist Care	$20 copayment per visit; $1,000 benefit max. per year for non-surgical care including physical therapy, combined in/out-of-network	$20 copayment per visit; $1,000 benefit max. per year for non-surgical care including physical therapy, combined in/out-of-network
Telemedicine	$10 copayment	$10 copayment
Wearable Hearing Aids	Cover wearable hearing aids every three years (after deductible) up to $3,500	Cover wearable hearing aids every three years (after deductible) up to $3,500

Notes:

* Benefits are based on reasonable charges.

** Some procedures require prenotification; some limits may apply.

***All copayments apply to the Annual Deductible and Out-of-Pocket Maximums.

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	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies
Infertility		
Precertification Requirements/Additional Benefit Limits	Precertification and required use of providers from Optum Fertility Solutions Network Centers of Excellence for all infertility consultations with a reproductive endocrinologist, and all infertility treatments (otherwise no coverage); lifetime maximum medical infertility limit for post-diagnosis services of $35,000 while covered under any AbbVie medical plan. Services to diagnose infertility are not included in the lifetime maximum	
Fertility Drugs	Covered under prescription drug benefit; lifetime fertility prescription drug max. of $25,000 while covered under any AbbVie medical plan	

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Benefits for Prescription Drugs	
Administered by CVS Caremark	Member Services: (855) 298-2488
Annual Deductible	$50 per individual; $100 per family
Annual Out of Pocket Limit	$1,800 per individual; $3,600 per family
Lifetime Infertility Maximum	$25,000 per individual while covered under any AbbVie medical plan
AbbVie and Allergan Products	
AbbVie and Allergan Prescription drugs	100% coverage for all AbbVie drugs before deductible
Single Source Brand and Generic Contraceptives	100% coverage
OTC female contraceptives (with prescription)	100% coverage
Breast Cancer Preventive for females age 35 or older	
Raloxifene, Tamoxifen Citrate, Anastrozole and Exemestane	100% coverage
Diabetes Meters and Supplies* **	
Diabetes Meters and Supplies	100% coverage
Statins	
Generic Statins for members age 40-75	100% coverage for low to moderate dose
HIV Pre-Exposure Prophylaxis (PrEP)	
Truvada (200mg-300mg) 1 tablet/day	100% coverage for brand until generic becomes available for preventive use only
All Other Prescriptions**	
Up to a 30-day supply at a retail network pharmacy	
Generic Medications	25% coinsurance ($5 min / $125 max) after deductible
Brand Medications	25% coinsurance ($15 min / $125 max) after deductible
84-90 Day Supply	Must obtain maintenance drugs through CVS Pharmacy or CVS Caremark Mail Service after 2 initial retail fills
Generic Medications	CVS Pharmacy 25%, Mail Service: 20% ($15 min / $250 max) after deductible
Brand Medications	CVS Pharmacy 25%, Mail Service: 20% ($35 min / $250 max) after deductible
90-day supply Value Generics	CVS Pharmacy or Mail Service: $10 for generic on the Value Generics Drug List*

* Drugs or products that are used for cosmetic (i.e. non-medical) purposes, or are available over the counter, are not covered

**Available only at CVS and through CVS/Caremark Mail Service. Coinsurance does not apply. To view the Value Generic Drug List, visit www.caremark.com

*** Continuous Glucose monitors, disposable pumps, and related supplies are covered in accordance with the plan's standard plan design" (deductible, coinsurance/copay)

****Member Pay the Difference Program**: If you fill a non-Company brand medication when a generic is available, you generally pay the difference in cost between the non-Company brand medication and the generic, plus the generic coinsurance/copay. Only the generic coinsurance/copay will count toward your plan deductible and/or out-of-pocket maximum, not the amount of the price differential between the two medications. If you or your physician have any questions concerning this program, please contact a CVS Customer Care representative at 1-855-298-2488. An exception to this provision may be considered and approved if medically necessary.