

# 2022 HEALTH CARE PLAN SUMMARIES

BCBS PPO - US Expats to Puerto Rico

Plan Code: M99

Basic Plan Information			
Plan Type:	PPO	Member Service	(877) 238-5951
Is a PCP Required?	No	Web Address	<a href="http://www.bcbsil.com/abbvie">www.bcbsil.com/abbvie</a>
Group Number	778113	Provider Network	PPO - Triple S

## 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; 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***	60% coverage after deductible
Annual Immunizations for Adults	100% coverage; adults age 18+ for adult immunizations as defined by the CDC and U.S. Preventive Services task force	60% coverage after deductible
Annual Screenings for Adults	100% coverage; adults age 18+ for recommended screenings as part of the annual physical exam	60% coverage after deductible
Annual Colorectal Screenings for Adults	100% coverage; adults age 40+ for colorectal cancer screening incl.: fecal occult blood test, flexible sigmoidoscopy, colonoscopy	60% coverage after deductible
Annual Bone Density Screenings for Adults	100% coverage; adults age 50+	60% coverage after deductible
Annual PSA Screening	100% coverage; adult males age 40+	60% coverage after deductible
Annual Well Woman Exam	100% coverage; for annual well woman exam (in addition to annual physical exam) incl. pap smear (ages 18+) and mammogram (age 35+)	60% coverage after deductible
Well Child Visits Under Age 2	100% coverage; well child visits based on American Academy of Pediatrics standards (0-12 months: 6 visits, 12-24 months: 3 visits) incl. all related blood and urine laboratory testing performed as part of the annual well child exam and determined necessary by patient's doctor	60% coverage after deductible
Well Child Visits Over Age 2	100% coverage; one annual well child exam (age 2 to 18) incl. all related blood and urine laboratory testing performed as part of the annual well child exam and determined necessary by patient's doctor	60% coverage after deductible
Childhood Immunizations	100% coverage; all recommended childhood immunizations, incl. HPV vaccine (excludes immunizations for travel)	60% coverage after deductible
Childhood Screenings	100% coverage; recommended screenings as part of the annual exam incl. health and developmental history, hearing, vision and skin screening	60% 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%

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	\$0	\$1,000 per person; \$2,000 per family
Out-of-Pocket Maximum	\$3,000 per person; \$7,500 per family	\$6,000 per person; \$15,000 per family
Lifetime Maximum	None	None
<b>Inpatient Benefits Prenotification required; \$250 penalty applies for failure to prenotify</b>		
Hospital Services	80% coverage	60% coverage after deductible
Maternity (newborn and delivery)	80% coverage	60% coverage after deductible; separate deductibles may apply to mother and baby
In-Hospital Physicians and Surgeons	80% coverage	60% coverage after deductible
<b>Outpatient Benefits</b>		
Ambulatory Surgery	80% coverage**	60% coverage after deductible**
Ambulance	80% coverage	80% coverage after deductible
Emergency Room	\$200 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 80%	\$200 copayment per visit; copayment waived if admitted; if not approved as emergency, covered at 60% after deductible
Urgent Care	\$50 copayment per visit	\$50 copayment per visit
Diagnostic X-Ray and Lab	80% coverage	60% coverage after deductible
<b>Physician and Professional Services</b>		
Office Visits	\$25 copayment per visit; excludes x-ray/lab	60% coverage after deductible
Maternity Physician Charges (delivery, prenatal, and first postnatal visit)	\$25 copayment for first OB visit, then 80% coverage	60% 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**	60% coverage after deductible
<b>Mental Health Benefits</b>		
	<i>Must precertify inpatient services; prenotification is required for all autism, biofeedback, electroshock therapy, hypnosis and psychological testing</i>	
Inpatient Services	80% coverage	60% coverage after deductible; a \$250 penalty applies for failure to precertify
Outpatient Services	\$25 copayment per visit	60% coverage after deductible
<b>Substance Abuse Benefits</b>		
<b>Mental Health Benefits</b>		
	<i>Must precertify inpatient services; prenotification is required for all autism, biofeedback, electroshock therapy, hypnosis and psychological testing</i>	
Inpatient Services	80% coverage	60% coverage after deductible; a \$250 penalty applies for failure to precertify
Outpatient Services	\$25 copayment per visit	60% coverage after deductible

**Notes:**

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

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<b>Other Benefits</b>		
Chiropractic Services	\$25 copayment per visit; \$1,000 benefit max. per calendar year combined in/out-of-network	\$25 copayment per visit; \$1,000 benefit max. per calendar year combined in/out-of-network
Physical Therapy	80% coverage	60% coverage after deductible
Home Health Care	80% coverage; 60 visits per calendar year combined in/out-of-network**	60% coverage after deductible; 60 visits per calendar year combined in/out-of-network**
Durable Medical Equipment	80% coverage**	60% coverage after deductible**
Hospice Care	80% coverage**	60% 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	\$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	\$25 copayment per visit; \$1,000 benefit max. per year for non-surgical care including physical therapy, combined in/out-of-network	\$25 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
<b>Infertility</b>		
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 drugs

## Contraceptives (include medications and devices)

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*

\* 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](http://www.caremark.com)