BCBS High Ded.

Plan Code: M4B/M4C

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

	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	60% 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)	60% 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	60% coverage after deductible
Annual Colorectal Screenings for Adults	100% coverage; ded. does not apply; colorectal cancer screening incl.: fecal occult blood test, flexible sigmoidoscopy, colonoscopy	60% coverage after deductible
Annual Bone Density Screenings for Adults	100% coverage; ded. does not apply	60% coverage after deductible
Annual PSA Screening	100% coverage; ded. does not apply;	60% 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 21+) and mammogram	60% coverage after deductible
Well Child Visits Under Age 2	100% coverage; ded. does not apply; well childcare 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; ded. does not apply; 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; ded. does not apply; all recommended childhood immunizations, incl. HPV vaccine (excludes immunizations for travel)	60% 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	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% 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*
Health Savings Account (HSA)	No employer HSA contribution. You may, however, contribute to an HSA account if eligible. HSA funds can be spent on qualified medical expenses. Unused HSA dollars are carried over to future calendar years. If you have family coverage, one person may use all available HSA funds.	
Annual Deductible	$2,300 employee only coverage; $4,600 family coverage (no individual deductibles or out-of-pocket maximums apply for family coverage)	$4,600 employee only coverage; $9,200 family coverage (no individual deductibles or out-of-pocket maximums apply for family coverage)
Out-of-Pocket Maximum	$4,275 employee only coverage; $8,550 family coverage. No individual deductibles or out-of-pocket maximums apply for family coverage	$8,550 employee only coverage; $17,100 family coverage. No individual deductibles or out-of-pocket maximums apply for family coverage
Lifetime Maximum	None	None
Inpatient Benefits	*Prenotification required; $250 penalty applies for failure to prenotify*	
Hospital Services	80% coverage after deductible	60% coverage after deductible
Maternity (newborn and delivery)	80% coverage after deductible; separate deductibles may apply to mother and baby	60% coverage after deductible; separate deductibles may apply to mother and baby
In-Hospital Physicians and Surgeons	80% coverage after deductible	60% coverage after deductible
Outpatient Benefits		
Ambulatory Surgery	80% coverage after deductible**	60% coverage after deductible**
Ambulance	80% coverage after deductible	80% coverage after in-network deductible
Emergency Room	80% coverage after deductible	80% coverage after in-network deductible; if not approved as emergency, covered at 60% after out-of-network deductible
Urgent Care	80% coverage after deductible	80% coverage after in-network deductible
Diagnostic X-Ray and Lab	80% coverage after deductible	60% coverage after deductible
Physician and Professional Services		
Office Visits	80% coverage after deductible	60% coverage after deductible
Maternity Physician Charges (delivery, prenatal, and first postnatal visit)	80% coverage after deductible	60% coverage after deductible**
Maternity Prenatal Care Screening and Lactation Support	100% coverage; deductible does not apply; for screening recommended by Affordable Care Act, lactation counseling and renting breast feeding equipment**	60% coverage after deductible**

Notes: * Benefits are based on reasonable charges. ** Some procedures require prenotification; some limits may apply.

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Plan Code: M4A/M4B

	Benefits for Covered In-Network Services and Supplies	Benefits for Covered Out-of-Network Services and Supplies*
Mental Health Benefits	Preauthorization 877- 238-5951	
Inpatient Services	80% coverage after deductible	60% coverage after deductible; A $250 penalty applies for failure to precertify
Outpatient Services	80% coverage after deductible	60% coverage after deductible
Inpatient Services	80% coverage after deductible	60% coverage after deductible; A $250 penalty applies for failure to precertify
Outpatient Services	80% coverage after deductible	60% coverage after deductible
Other Benefits		
Chiropractic Services	80% coverage after deductible; $1,000 benefit max. per year combined in/out-of-network; benefit max. applies to services after deductible is met	80% coverage after deductible; $1,000 benefit max. per year combined in/out-of-network; benefit max. applies to services after deductible is met
Physical Therapy	80% coverage after deductible	60% coverage after deductible
Home Health Care	80% coverage after deductible; 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 after deductible**	60% coverage after deductible**
Hospice Care	80% coverage after deductible**	60% coverage after deductible**
Vision Benefits	80% coverage after deductible for one routine exam per calendar year; eyewear not covered; combined in/out-of-network benefit	60% coverage after deductible for one routine exam per calendar year; eyewear not covered; combined in/out-of-network benefit
Podiatrist Care	80% coverage after deductible; $1,000 benefit max. per year for non-surgical care including physical therapy, combined in/out-of-network; benefit max applies to services after deductible is met	60% coverage after deductible; $1,000 benefit max. per year for non-surgical care including physical therapy, combined in/out-of-network; benefit max applies to services after deductible is met
Telemedicine	90% coverage after deductible	N/A

Notes: * Benefits are based on reasonable charges. ** Some procedures require prenotification; some limits may apply.

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Fertility

Fertility medical and prescription drug	Offered through Maven only, must register and use Maven network. Access to 2 Maven Cycles per household lifetime maximum for eligible fertility expenses. Register through Maven at 877-228-5919

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Plan Code: M4A/M4B

Benefits for Prescription Drugs	
Administered by CVS Caremark	Member Services: (855) 298-2488
Annual Deductible	Combined with the plan's annual deductible
Annual Out of Pocket Limit	Combined with the plan's out of pocket limit
Contraceptives (include medications and devices)	
Single Source Brand and Generic Contraceptives	100% coverage
OTC female contraceptives (with prescription)	100% coverage
Preventive Drugs	
	Brand Name Drugs- subject to standard Rx plan design with coinsurance. No deductible needs to be met. Generic Drugs-- 100% coverage before deductible and subject to standard Rx plan design with coinsurance after deductible has been met.
Breast Cancer Preventive for females age 35 or older	
Raloxifene, Tamoxifen Citrate, Anastrozole, and Exemestane	100% coverage
Diabetes Supplies**	
Diabetes Supplies	100% coverage after deductible for diabetes supplies (alcohol swabs, lancets, syringes and test strips)
Statins	
Generic Statins for members age 40-75	100% coverage for low to moderate dose
HIV Pre-Exposure Prophylaxis (PrEP)	
Emtricitabine/Tenofovir (Generic Truvada), Descovy, Apretude	100% coverage for preventive use only
All Other Prescriptions***	
Up to a 30-day supply at a retail network pharmacy	
Generic Medications	25% coinsurance ($5 min / $200 max) after deductible
Brand Medications	25% coinsurance at CVS Retail ($15 min / $200 max) after deductible
84-90 Day Supply	Must obtain maintenance drugs through CVS Pharmacy or CVS Caremark Mail Service after 2 initial fills at a retail pharmacy
Generic Medications	CVS Pharmacy: 25%($15 min / $400 max) Mail Service: 20% ($15 min / $400 max) after deductible
Brand Medications	CVS Pharmacy: 25%($35 min / $400 max) Mail Service: 20% ($35 min / $400 max) after deductible

* 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