Medical Coverage

- HP Tuners offers a choice of medical plan options so you can choose the Medical Coverage plan that best meets your needs and those of your family.
- The medical plans are administered by BlueCross/BlueShield of Illinois.

Note: This is a summary of coverage only. Please refer to the summary of benefits coverage for complete information. In-network services are based on negotiated charges; out-of-network services are based on Reasonable and Customary (R&C) charges.

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The Cost of Your Benefits

HP Tuners pays full cost for some of your benefits; you share the cost for others.

Below are the 2022-2023 Per Pay Period Contributions.

Benefit	You Pay – Per Pay Period			
	Employee Only	Employee/Children	Employee/Spouse	Family
Medical Coverage				
Blue Advantage HMO	$23.23	$75.84	$80.39	$137.50
Blue Choice Options PPO	$25.11	$93.49	$86.90	$140.00
Blue Edge H.S.A PPO	$24.76	$92.17	$85.67	$140.70
Blue Print PPO	$27.78	$86.48	$96.13	$157.88
Dental Coverage	$0	$22.21	$22.46	$46.87
Vision Coverage	$0	$5.13	$9.14	$10.37

HPtuners

Medical Coverage

Plan Provisions	Blue Advantage HMO Plan		Blue Choice Options PPO Plan			H.S.A PPO Plan		Blue Print PPO Plan	
Network	BLUE PRECISION HMO	Out-of-Network	BLUE CHOICE Tier 1	PPO Tier 2	Out-of-Network	In-Network PPO Plan	Out-of-Network PPO Plan	In-Network PPO Plan	Out-of-Network PPO Plan
Annual Deductible (Individual/Family)	None	NO COVERAGE	$500 $1,500	$1,750 $5,250	$3,000 $9,000	**$2,900** $5,600	$5,600 $11,200	$1,000 $3,000	$2,000 $6,000
Co-insurance	100%	N/A	90%	70%	50%	100%	100%	80%	60%
Out-of-Pocket Max (Individual/Family) (Includes Deductible/Copays)	$1,500 $3,000		$4,000 $10,200	$5,600 $10,200	$16,800 $30,600	$3,500 $10,500	$5,600 $11,200	$4,000 $12,000	$12,000 $36,000
Lifetime Maximum	Unlimited		Unlimited			Unlimited		Unlimited	
Preventative Care	100%		100%	100%	50% after deductible	100%	100% after deductible	100%	40% after deductible
Primary Physician Office Visit	$20 copay		$20 copay	$50 copay	50% after deductible	No charge after ded.	No charge after ded.	$30 copay	40% after deductible
Specialist Office Visit	$40 copay		$40 copay	$100 copay	50% after deductible	No charge after ded.	No charge after ded.	$50 copay	40% after deductible
Virtual	n/a		$20 copay	$20 copay	n/a	No charge after deductible	No charge after deductible	$0 copay	n/a
Inpatient Hospital Services	100%		$250 copay/visit plus 10%	$500 copay/visit plus 30%	$600 copay/visit plus 50%	No charge after deductible	No charge after deductible	20% after deductible	40% after deductible plus $300/visit
Outpatient Hospital Services	100%		$200 copay/visit plus 10%	$400 copay/visit plus 30%	$500 copay/visit plus 50%	No charge after deductible	No charge after deductible	20% after deductible plus $200/visit	40% after deductible
Urgent Care	$20 PCP $40 specialist		$75 copay (No Deductible)	$75 copay (No Deductible)	$75 copay (No deductible)	No charge after deductible	No charge after deductible	20% after deductible	40% after deductible
Emergency Room Care	$250/visit		$400 copy/visit plus 10%	$500 copy/visit plus 20%	$400 copy/visit plus 10%	No charge after deductible	No charge after deductible	$150 copay No deductible	$150 copay No deductible
Retail Prescriptions (30-day supply)									
Formulary Generic	$0 copay		$0 copay		$10 copay	No charge after deductible		$0/$10 copay	
Non-Formulary Gen	$10 copay		$10 copay		$20 copay				
Formulary Brand Name	$50 copay		$35 copay		$55 copay			$50 copay	
Non-Formulary Brand	$100 copay		$75 copay		$95 copay			$100 copay	
Specialty Drugs	$150/$250 copay		$150/$250 copay					$150/$250 copay	
Mail Order Prescriptions (90-day supply)	2X Copay		2X Copay	2X Copay	2X Copay			2X Copay	

Dental Coverage

- Regular dental exams can help you and your dentist detect problems in the early states when treatment is simpler, and costs are lower.
- Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your medical health.

- The dental pans are administered by PRINCIPAL

Plan Provision	Base Dental Plan	
	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50/$150	
Annual Maximum (Per person)	$1,500	
Diagnostic and Preventive Care: Includes cleanings, fluoride treatments, X-Rays	100% No deductible	
Basic Services: Includes fillings, scaling and root planning, and oral surgery	80% after deductible	
Major Services: Implants, includes crowns, bridges and full and partial dentures	50% after deductible	
Orthodontia	None	

Note: Remember that it costs you less if you use a network provider.
Out of Network services are subject to Usual & Customary fees.