



2015 PPO BENEFIT PLAN SUMMARY

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
<p>Deductible, Co-Insurance and Calendar Year Out-of- Pocket Limit</p> <p>Note: The deductible is included when calculating the annual out-of-pocket limit.</p>	<p>\$300 individual annual deductible (\$600 family), then plan pays 85% of eligible charge. Calendar year out-of-pocket limit for in-network expenses of \$2550 for single, \$5100 for single plus one, and \$7350 for family, then plan pays 100% for the remainder of the calendar year.</p>	<p>\$300 individual annual deductible (\$600 family), then plan pays 70% of eligible charge. Calendar year out-of-pocket limit for out-of-network expenses of \$2800 for single, \$5600 for single plus one, and \$8100 for family, then plan pays 100% of eligible charges for the remainder of the calendar year.</p>
Preventive Care Services	Includes general health screenings for newborns, children and adults, immunizations, cancer screenings, health counseling and women's preventive services. Covered at 100% with no deductible or co-insurance when in-network provider is used.	Most Preventive Care Services are not covered if out-of-network provider is used. The exception is for well child care up to age 3, well-woman exam with pap and mammogram, prostate screening exam with PSA test, fecal occult blood test for colorectal cancer screening, and HPV vaccine. The plan will pay 70% of the eligible charge after deductible.
General Hospital Admission, In-Hospital Services, Supplies and Anesthesiology	85% of eligible charge after deductible.	70% of eligible charge after deductible.
Blue Distinction Centers (BDC) and Blue Distinction Centers + (BDC+)	90% of eligible charge after deductible using a BDC and 95% of eligible charge after deductible using a BDC+ for certain specialty care areas.	Not applicable.
Out-Patient Surgery In-Patient Surgery	85% of eligible charge after deductible. 85% of eligible charge after deductible.	70% of eligible charge after deductible. 70% of eligible charge after deductible.
Out-Patient X-Ray and Laboratory	85% of eligible charge after deductible. If test is part of preventive care services, then it is paid at 100%.	70% of eligible charge after deductible. If test is part of preventive care services, then may not be covered.
Emergency Care	85% of eligible charge after deductible.	85% of eligible charge after deductible.
Physicians Visits: In-Hospital, Office Visits, and Consultations	85% of eligible charge after deductible.	70% of eligible charge after deductible.
Chiropractic Visits:	85% of eligible charge after deductible limited to 40 visits per calendar year.	70% of eligible charge after deductible limited to 40 visits per calendar year.
Routine Vision Care	Not covered, but program through Davis Vision allows discounts on eye exams, glasses and contacts. Call 1-877-393-8844 for a list of participating providers.	Not covered, but program through Davis Vision allows discounts on eye exams, glasses and contacts. Call 1-877-393-8844 for a list of participating providers.

*In-network and out-of-network expenses will be applied equally toward the satisfaction of both the in-network and out-of-network out-of-pocket maximums.

2015 PPO BENEFIT PLAN SUMMARY (CONTINUED)

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
Home Health Care	85% of eligible charge after deductible up to 40 days per calendar year.	70% of eligible charge after deductible to 40 days per calendar year.
Skilled Nursing Facility	85% of eligible charge after deductible up to 60 days per calendar year.	70% of the eligible charge up to 60 days per calendar year.
Hospice Care	85% of eligible charge after deductible.	70% of the eligible charge after deductible.
Mental Health and Substance Abuse	85% of eligible charge after deductible.	70% of the eligible charge after deductible.
Pre-Authorization Requirement	Pre-authorization required prior to hospitalization or within 48 hours of emergency admission, skilled nursing or mental health/substance care treatment.	Pre-authorization required prior to hospitalization or within 48 hours of emergency admission, skilled nursing or mental health/substance care treatment.
<p>Prescription Drug Plan <i>Cost included with health care plan. Deductible and co-insurance maximums separate from Medical and Dental Plans.</i></p> <p>No deductible for prescription drugs. Annual out-of-pocket maximum for all drugs, including retail, mail order and specialty is \$2,000/person, \$4,000/family.</p>	<p>Generic Drugs: 30 Day Retail: 20% (minimum \$10) Mail Order: 20% (minimum \$20) Retail 90: 20% (minimum \$25)</p> <p>Preferred Brand Drugs: 30 Day Retail: 25% (no min/no max) Mail Order: 25% (maximum \$75) Retail 90: 25% (maximum \$85)</p> <p>Non-Preferred Brand Drugs: 30 Day Retail: 40% (no min/no max) Mail Order: 40% (maximum \$110) Retail 90: 40% (maximum \$125)</p> <p>Specialty Drugs: Retail Pharmacy: 20% (1st fill only) Specialty Pharmacy: 20% (30 day)</p> <p>Note: When a generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.</p>	<p>Generic Drugs: 30 Day Retail: 20% (minimum \$10) Mail Order: 20% (maximum \$60) Retail 90: 20% (maximum \$70)</p> <p>Preferred Brand Drugs: 30 Day Retail: 25% Mail Order: 25% (maximum \$75) Retail 90: 25% (maximum \$85)</p> <p>Non-Preferred Brand Drugs: 30 Day Retail: 40% Mail Order: 40% (maximum \$110) Retail 90: 40% (maximum \$125)</p> <p>Specialty Drugs: Retail Pharmacy: 20% (1st fill only) Specialty Pharmacy: 20% (30 day)</p> <p>Note: When a generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.</p>
<p>Delta Dental PPO Dental Plan <u>Can take alone or with health care plan.</u> <i>Deductible and out-of-pocket maximums separate from Medical and Prescription Drug Plans.</i></p> <p>In-network includes PPO or Premier. PPO provider accepts discounted rates and Premier provider agrees not to charge over allowed amount.</p>	<p>\$100 individual annual deductible, \$300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of eligible charge each calendar year include 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person \$2000. Orthodontic lifetime maximum per person \$2000.</p>	<p>\$100 individual annual deductible, \$300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of eligible charge each calendar year include 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person \$2000. Orthodontic lifetime maximum per person \$2000.</p>

*In-network and out-of-network expenses will be applied equally toward the satisfaction of both the in-network and out-of-network out-of-pocket maximums.