



BLUE CROSS BLUE SHIELD OF ILLINOIS (BCBSIL) 2012 PREFERRED PROVIDER OPTION (PPO) BENEFIT PLAN SUMMARY

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
Deductible, Co-Insurance and Calendar Year Out-of- Pocket Limit	\$300 individual annual deductible (\$600 family), then plan pays 85% of contracted rate. Calendar year out-of-pocket limit for in-network expenses of \$2250 for single, \$4500 for single plus one, and \$6750 for family (\$2250 for up to 3 family members) plus deductible, then plan pays 100% for the remainder of the calendar year.	\$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 \$2500 for single, \$5000 for single plus one, and \$7500 for family (\$2500 for up to 3 family members) plus deductible, then plan pays 100% of the eligible charges for the remainder of the calendar year.
Preventive Care Services	Includes general health screenings for newborns, children and adults, immunizations, cancer screenings and health counseling . See list of covered 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 (includes immunizations), well-woman exam that includes pap and mammogram, prostate screening exam that includes PSA test, fecal occult blood test for colorectal cancer screening, and HPC vaccine for females ages 11-17. For these specific services, the plan will pay 70% of the eligible charge after deductible.
General Hospital Admission	85% of contracted rate after deductible.	Inpatient covered services at 70% of eligible charge after deductible.
In-Hospital Services, Supplies, and Anesthesiology	85% of contracted rate after deductible.	70% of the eligible charge after deductible.
Out-Patient Surgery In-Patient Surgery	85% of contracted rate after deductible. 85% of contracted rate after deductible.	70% of the eligible charge after deductible. 70% of the eligible charge after deductible.
Out-Patient X-Ray and Laboratory	85% of contracted rate after deductible. If test is part of preventive care services, then it is paid at 100%.	70% of the eligible charge after deductible. If test is part of preventive care services, then it is not covered.
Emergency Care	85% of contracted rate after deductible.	85% of the eligible charge after deductible.
Physicians Visits: In-Hospital, Office Visits, and Consultations	85% of contracted rate after deductible.	70% of the eligible charge after deductible.
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.

PPO BENEFIT PLAN SUMMARY (CONTINUED)

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
Home Health Care	85% of contracted rate after deductible up to 40 days per calendar year.	70% of the eligible charge after deductible to 40 days per calendar year.
Skilled Nursing Facility	85% of contracted rate after deductible up to 60 days in a calendar year.	70% of the eligible charge up to 60 days in a calendar year.
Hospice Care	85% of contracted rate after deductible.	70% of the eligible charge after deductible.
Mental Health and Substance Abuse	85% of contracted rate after deductible.	70% of the eligible charge after deductible.
Medical Services	Pre-certification required prior to hospitalization or within 48 hours of emergency admission. Case management.	Pre-certification required prior to hospitalization or within 48 hours of emergency admission. Case management.
<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 retail drugs \$1500/person, \$3000/family. Retail 30 day supply: Generic: 20% (minimum \$10) Brand: 25% (minimum \$20) Retail 90 day supply: Generic: \$25 Brand: \$55 Mail Order 90 day supply: Generic: \$20 Brand: \$50 Annual out of pocket maximum does not apply on Retail 90 or mail order. Specialty Drugs: \$20% with separate maximum of \$750/person, \$1500/family. <u>When generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.</u></p>	<p>No deductible for prescription drugs. Annual out of pocket maximum for retail drugs \$1500/person, \$3000/family. Retail 30 day supply: Generic: 20% (minimum \$10) Brand: 25% (minimum \$20) Retail 90 day supply: Generic: \$25 Brand: \$55 Mail Order 90 day supply: Generic: \$20 Brand: \$50 Annual out of pocket maximum does not apply on Retail 90 or mail order. Specialty Drugs: \$20% with separate maximum of \$750/person, \$1500/family. <u>When generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.</u></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 contracted rate each calendar year includes 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. \$2000 lifetime orthodontic benefit.</p>	<p>\$100 individual annual deductible, \$300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of allowed amount each calendar year includes 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. \$2000 lifetime orthodontic benefit.</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.