



2010 BCBS PPO – Option B750

Health plan administered by BlueCross BlueShield (BCBS) of Illinois: 1-866-804-0976 www.gbophb.org
Pharmacy plan administered by Medco Health: 1-800-841-2806 Behavioral health plan administered by United Behavioral Health (UBH): 1-800-788-5614

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit*
Lifetime Benefit Maximum	<ul style="list-style-type: none"> \$3,000,000 	<ul style="list-style-type: none"> \$3,000,000
Annual Deductible Co-payments are not included in annual deductible.	<ul style="list-style-type: none"> \$750 per person \$1,500 per family 	<ul style="list-style-type: none"> \$1,500 per person \$3,000 per family
Annual Out-of-Pocket Limit Includes annual deductible and co-insurance; excludes any charges in excess of Reasonable & Customary* charges and non-participating hospital admission co-payments.	<ul style="list-style-type: none"> \$3,500 per person \$7,000 per family 	<ul style="list-style-type: none"> \$7,000 per person \$14,000 per family
Co-insurance (plan pays)	<ul style="list-style-type: none"> 80% after deductible 	<ul style="list-style-type: none"> 60% after deductible
Pre-Notification and Medical Management Review Call 1-866-804-0976	To ensure maximum benefits, <i>pre-notification is required</i> for certain services. Please see the HealthFlex Benefit Booklet for a complete list, or call the number on the left.	
Pre-Notification for Behavioral Health Services Call 1-800-788-5614	To ensure maximum benefits for behavioral health services, please see the United Behavioral Health certificate of insurance for information, or call the number on the left.	
Maximum Allowance	<p>All benefit payments for covered services, including Emergency Services, rendered by Participating and Non-Participating Providers are limited to the Maximum Allowance for the service, as determined by BCBS based on reasonable and customary amounts.</p> <p>Participating Providers have signed an agreement with BCBS to accept the Maximum Allowance as payment in full. Participating Providers have agreed not to bill you for amounts in excess of the Maximum Allowance.</p> <p>Non-Participating Providers have not signed an agreement with BCBS to accept the Maximum Allowance as payment in full. Therefore you are responsible for the difference between the Maximum Allowance and the Provider's charge.</p>	

* Any and all benefits paid are subject to the Reasonable & Customary provisions of the Plan; meaning charges are limited to the Maximum Allowance under the Plan and covered individuals will be responsible for amounts providers charge in excess of the Maximum Allowance.

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit*
<p>Primary Care Physician (PCP) Office Visits Primary care physicians include internists, general and family practitioners, obstetricians, gynecologists and pediatricians.</p>	<ul style="list-style-type: none"> • \$30 co-payment, then plan pays 100% 	<ul style="list-style-type: none"> • 60% after deductible
<p>Outpatient Short-Term Rehabilitative Therapy</p> <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech therapy <p>Physical and occupational therapy: Combined \$6,000 calendar year maximum. Speech therapy: \$4,000 calendar year maximum.</p>	<ul style="list-style-type: none"> • \$30 co-payment, then plan pays 100% • \$30 co-payment, then plan pays 100% • \$30 co-payment, then plan pays 100% 	<ul style="list-style-type: none"> • 60% after deductible • 60% after deductible • 60% after deductible
<p>Specialist Office Visits</p>	<ul style="list-style-type: none"> • \$50 co-payment, then plan pays 100% • Allergy injections only, plan pays 100% 	<ul style="list-style-type: none"> • 60% after deductible • 60% after deductible
<p>Preventive Care</p> <p>Well Child Benefits (Under age 16)</p> <ul style="list-style-type: none"> • Includes charges for office visits, age appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children over the age of two. <p>Well Adult Benefits (16 and Over)</p> <ul style="list-style-type: none"> • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer. • Colonoscopy (Covered once every three years for participants age 45 and older.) 	<ul style="list-style-type: none"> • 100% • \$30 co-payment if PCP, then plan pays 100%; \$50 co-payment if specialist, then plan pays 100% • \$100 co-payment, then plan pays 100% 	<ul style="list-style-type: none"> • 100% up to a \$100 calendar year maximum benefit payable for all services (office visits, exams and tests) • 100% up to a \$100 calendar year maximum benefit payable for all services (office visits, exams and tests) • 60% after deductible
<p>Licensed Dietitian Office visit</p>	<ul style="list-style-type: none"> • \$30 co-payment, then plan pays 100% 	<ul style="list-style-type: none"> • \$30 co-payment, then plan pays 100%
<p>Outpatient Diagnostic Services and Treatment</p> <ul style="list-style-type: none"> • Physician office • Hospital, independent lab and x-ray facility 	<ul style="list-style-type: none"> • \$30 co-payment if PCP, then plan pays 100%; \$50 co-payment if specialist, then plan pays 100% • 80% after deductible 	<ul style="list-style-type: none"> • 60% after deductible • 60% after deductible

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit*
Outpatient Services/Ambulatory Surgery Includes surgery in the physician's office.	<ul style="list-style-type: none"> • 80% after deductible 	<ul style="list-style-type: none"> • 60% after deductible
Inpatient Hospital Care <i>Pre-notification required.</i>	<ul style="list-style-type: none"> • 80% after deductible 	<ul style="list-style-type: none"> • \$200 per admission hospital co-payment then 60% after plan deductible
Transplant <i>Pre-notification required.</i>	<ul style="list-style-type: none"> • 80% after deductible at a Blue Distinction Center for Transplant 	<ul style="list-style-type: none"> • Not covered
Emergency Care <ul style="list-style-type: none"> • Primary care physician office visit • Specialist physician office visit • Hospital emergency room • Outpatient facility or other urgent care facility • Ambulance (medical emergency) 	<ul style="list-style-type: none"> • \$30 co-payment if PCP, then plan pays 100% • \$50 co-payment if specialist, then plan pays 100% • \$50 co-payment** then plan pays 100% • \$50 co-payment** then plan pays 100% • 80% after deductible <p>** Waived if Admitted</p>	<ul style="list-style-type: none"> • \$30 co-payment if PCP, then plan pays 100% (not covered unless a true Emergency as defined in the Plan, then 60% after deductible) • \$50 co-payment if specialist, then plan pays 100% (not covered unless a true Emergency as defined in the Plan, then 60% after deductible) • \$50 co-payment** then plan pays 100% (not covered unless a true Emergency as defined in the Plan, then 60% after deductible) • \$50 co-payment** then plan pays 100% (not covered unless a true Emergency as defined in the Plan, then 60% after deductible) • 80% after deductible (not covered unless a true Emergency as defined in the Plan) <p>** Waived if Admitted</p>
Maternity Care/Physician Charges If you enroll in your first trimester and participate in the Healthy Expectations program, you will receive a gift after you complete the program. To enroll, call 1-866-804-0976. <i>Pre-notification required.</i>	<ul style="list-style-type: none"> • \$30 co-payment for initial visit to confirm pregnancy • 80% after the deductible for all subsequent physician charges for prenatal visits, postnatal visits and delivery 	<ul style="list-style-type: none"> • 60% after deductible • 60% after deductible for all subsequent physician charges for prenatal visits, postnatal visits and delivery
Newborn Routine Nursery Inpatient Services	<ul style="list-style-type: none"> • 80% 	<ul style="list-style-type: none"> • 60% after deductible

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit*
<p>Alternative Therapies</p> <ul style="list-style-type: none"> • Chiropractic care • Massage therapy • Acupuncture • Naprapathy <p>Combined \$1,000 calendar year maximum.</p>	<ul style="list-style-type: none"> • \$30 co-payment, then plan pays 100% • 50% • 50% • 50% 	<ul style="list-style-type: none"> • 50% after deductible • 50% • 50% • 50%
<p>Special Services</p> <ul style="list-style-type: none"> • Skilled Nursing Facility: 120 days maximum per calendar year • Private Duty Nursing: \$2,000/ month maximum • Home Health Care: 60-visit maximum per calendar year • Hospice <p><i>Pre-notification required.</i></p>	<ul style="list-style-type: none"> • 80% after deductible • 80% after deductible • 80% after deductible • 80% after deductible 	<ul style="list-style-type: none"> • 60% after deductible • 60% after deductible • 60% after deductible • 60% after deductible
<p>Hearing Benefit</p> <ul style="list-style-type: none"> • Hearing aids – Every 24 months • Exam 	<ul style="list-style-type: none"> • 50% up to \$500 per ear • \$50 co-payment, then plan pays 100% 	<ul style="list-style-type: none"> • 50% up to \$500 per ear • 60% after deductible

This summary highlights some of the features of this benefit plan. The summary is for illustrative purposes only and is subject to change at any time. The controlling terms and conditions of the benefit plan are contained in the Plan Document, Summary Plan Description and the HealthFlex Benefit Booklet (collectively, the “Documents”) maintained by the General Board of Pension and Health Benefits. If there are any conflicts between this summary and the terms of the Documents, the terms of the Documents shall control.