

# Blue Cross and Blue Shield Basic PPO Plan

Member Services 800-435-0108 [www.bcbsil.com/accenture](http://www.bcbsil.com/accenture)

Effective 1-1-11

Annual Deductibles	In-Network	Out-of-Network
The amount you pay each year before the plan begins covering your medical expenses.	Individual \$800 Family \$1,600	Individual \$2,500 Family \$5,000
Annual Out of Pocket Maximums	In-Network	Out-of-Network
Total amount you pay out-of-pocket in one calendar year before the plan pays 100% of your medical expenses.	Individual \$3,000 Family \$6,000	Individual \$5,000 Family \$10,000
Lifetime Maximum	Unlimited	Unlimited
Hospital	In-Network	Out-of-Network
<b>Inpatient Hospital Services</b> Room allowance is based on the hospital's most common semi-private room rate. Pre-Admission Testing, Skilled Nursing Facilities, Hospice and Coordinated Health Care are also paid on the same basis.	Deductible, then 80%	Deductible, then 60%
<b>Outpatient Surgery and Diagnostic Tests</b> Includes x-rays, blood tests, CAT scans, MRIs, and diagnostic mammograms.	Deductible, then 80%	Deductible, then 60%
<b>Outpatient Hospital Service</b> Including Radiation and Chemotherapy	Deductible, then 80%	Deductible, then 60%
<b>Hospital Emergency Medical/Accident Care</b> If an inpatient admission occurs, the deductible and inpatient 80% coinsurance applies. Pre- Notification must be contacted within two business days.	Deductible, then 80%	Deductible, then 80%
Mental Health and Substance Abuse Services	In-Network	Out-of-Network
<b>Mental Health Services</b> Pre- notification required for all Mental Health services.	Deductible, then 80%	Deductible, then 60%
<b>Substance Abuse Services</b> Pre- notification required for all Substance Abuse services.	Deductible, then 80%	Deductible, then 60%
Physician Services	In-Network	Out-of-Network
<b>Preventive Physician Office Visits</b> , consultation, well care exam	100%	Not Covered
<b>Diagnostic Office Visits</b> , consultation	Deductible, then 80%	Deductible, then 60%
<b>Medical/Surgical Benefits or Inpatient/Outpatient Physician Services</b> Includes radiologist's, anesthesiologist's and surgeon's charges.	Deductible, then 80%	Deductible, then 60%
Maternity Care	In-Network	Out-of-Network
<b>Physician Office Visits</b> Initial office visit with pregnancy diagnosis. (Subsequent pre- and post-natal visits are considered part of the global fee for physician services for the delivery)	Deductible, then 80%	Deductible, then 60%
<b>Labs/Ultrasounds</b>	Deductible, then 80%	Deductible, then 60%
<b>Inpatient Hospital Services</b>	Deductible, then 80%	Deductible, then 60%
Well-Care Benefits	In-Network	Out-of-Network
<b>Wellness Care</b> Provides coverage for routine physical exams, immunizations, routine diagnostic tests, routine mammograms, routine pap smear tests, PSA tests, and well child care	100%	Not Covered
Other Covered Services	In-Network	Out-of-Network
<b>Chiropractic Services</b> (\$1,000 calendar year maximum combined in- or out-of-network)	Deductible, then 80%	Deductible, then 60%
<b>Infertility</b> (\$20,000 lifetime maximum per family combined in- or out-of-network for Rx and Medical Combined)	Deductible, then 80%	Deductible, then 60%
<b>Independent Lab Services</b>	Deductible, then 80%	Deductible, then 60%
<b>Physical, Speech and Occupational Therapy</b> (Services will be reviewed for medical necessity)	Deductible, then 80%	Deductible, then 60%
<ul style="list-style-type: none"> <li>• <b>Dietician Visits</b> - Plan covers up to 4 annual dietician visits for children ages 3-18</li> <li>• <b>Non- Emergency Ambulance</b></li> <li>• <b>Durable Medical Equipment and Prosthetics</b> (Rental price covered up to the purchase price)</li> <li>• <b>Blood and blood components</b></li> <li>• <b>Leg, arm and neck braces</b></li> <li>• <b>Oxygen</b> (includes administration)</li> <li>• <b>Surgical dressings</b></li> <li>• <b>Casts and splints</b></li> </ul>	Deductible, then 80%	Deductible, then 60%

Prescription Drugs	In-Network	Out-of-Network
<b>Retail</b> (up to a 34 day supply)	Generic – you pay \$10 copay  Formulary Brand – you pay 25% coinsurance (\$35 minimum, \$55 maximum)  Non-Formulary Brand – you pay 25% coinsurance (\$50 minimum, \$70 maximum)	You pay 40% coinsurance No deductible applies
<b>Mail Order through Prime Therapeutics Pharmacy Mail Order</b> (up to a 90 day supply)	Generic –you pay \$25 copay  Formulary Brand – you pay 25% coinsurance (\$70 minimum, \$110 maximum)  Non-Formulary Brand – you pay 25% coinsurance (\$100 minimum, \$140 maximum)	Not Covered
<b>Maintenance Medications through Walgreens Retail</b> (90 day supply)	Generic –you pay \$25 copay  Formulary Brand – you pay 25% coinsurance (\$87.50 minimum, \$137.50 maximum)  Non-Formulary Brand – you pay 25% coinsurance (\$125 minimum, \$175 maximum)	Not Covered
<b>Maintenance medication prescriptions must be filled through Prime Therapeutics Pharmacy Mail Order at (800) 423-1973 or Walgreens Retail</b> <b>Specialty medication prescriptions must be filled through Triessent Specialty Pharmacy at (888) 216-6710</b> <b>Find additional information at <a href="http://www.bcbsil.com/accnture">www.bcbsil.com/accnture</a> under the RX Drugs tab.</b>		
<b>Basic Provisions</b>		
Pre- Notification:  Transplant Coverage:  Vision: Hearing: Other Covered Services:  Preventive Care:	Notification required prior to all elective admissions. Emergency and obstetric inpatient admission notification required within 2 business days of admittance. Notification required prior to all infertility services. Failure to notify for infertility services will result in a \$500 penalty. Notification required prior to all Mental Health/ Substance Abuse Services.  Cornea, kidney, bone marrow, heart valve, heart, heart/lung, pancreas, and pancreas/kidney, muscular-skeletal or parathyroid human organ or tissues. Transplants are paid as any other condition but must have prior procedural and facility approval by Utilization Management.  Routine vision care and hardware covered through EyeMed at (877) 735-9322. One routine hearing exam per calendar year. Unlimited diagnostic exams. In some locations, Blue Cross and Blue Shield does not solicit PPO contracts with ancillary providers. In locations where these providers are not solicited, Blue Cross and Blue Shield will pay benefits at the PPO level. PPO providers may be found using the Provider Finder at <a href="http://www.bcbsil.com/accnture">www.bcbsil.com/accnture</a> . Contact Member Services for preventive care coverage specifics.	
<i>Note: This is intended as a brief summary of benefits. The Contracts and Master Plan Document govern in all cases. Not all covered services, exclusions and limitations are shown here.</i>		
At Blue Cross and Blue Shield of Illinois (BCBSIL), we are committed to eco-friendly business practices. Explanation of Benefit (EOB) statements and history are available 24/7 on Blue Access for Members (BAM) at <a href="http://www.bcbsil.com/accnture">www.bcbsil.com/accnture</a> to view or print. (Registration Required) You can request that electronic EOBs with payment information be e-mailed to you. If the EOB is accompanied by a check, it will be mailed out immediately.		