

BlueCross BlueShield Basic PPO Plan

Member Services (800) 435-0108

www.bcbsil.com/accnture

Effective 1-1-10

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
Inpatient Hospital Services 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%
Outpatient Surgery and Diagnostic Tests Includes x-rays, blood tests, CAT scans, MRIs, and diagnostic mammograms.	Deductible, then 80%	Deductible, then 60%
Outpatient Hospital Service Including Radiation and Chemotherapy	Deductible, then 80%	Deductible, then 60%
Hospital Emergency Medical/Accident Care 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
Mental Health Services Pre- notification required for all Mental Health services. Members in treatment prior to January 1, 2010 must contact Customer Service to continue to receive benefits after January 1, 2010.	Deductible, then 80%	Deductible, then 60%
Substance Abuse Services Pre- notification required for all Substance Abuse services. Members in treatment prior to January 1, 2010 must contact Customer Service to continue to receive benefits after January 1, 2010.	Deductible, then 80%	Deductible, then 60%
Physician Services	In-Network	Out-of-Network
Preventive Physician Office Visits , consultation, well care exam	100%	Not Covered
Diagnostic Office Visits , consultation	Deductible, then 80%	Deductible, then 60%
Medical/Surgical Benefits or Inpatient/Outpatient Physician Services Includes radiologist's, anesthesiologist's and surgeon's charges.	Deductible, then 80%	Deductible, then 60%
Maternity Care	In-Network	Out-of-Network
Physician Office Visits 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%
Labs/Ultrasounds	Deductible, then 80%	Deductible, then 60%
Inpatient Hospital Services	Deductible, then 80%	Deductible, then 60%
Well-Care Benefits	In-Network	Out-of-Network
Wellness Care 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
Chiropractic Services (\$1,000 calendar year maximum combined in- or out-of-network)	Deductible, then 80%	Deductible, then 60%
Infertility (\$20,000 lifetime maximum per family combined in- or out-of-network for Rx and Medical Combined)	Deductible, then 80%	Deductible, then 60%
Independent Lab Services	Deductible, then 80%	Deductible, then 60%
Physical, Speech and Occupational Therapy (\$2,000 per therapy calendar year maximum combined in- and out-of-network; additional visits may be available if approved as medically necessary)	Deductible, then 80%	Deductible, then 60%
<ul style="list-style-type: none"> • Non- Emergency Ambulance • Durable Medical Equipment and Prosthetics (Rental price covered up to the purchase price) • Blood and blood components • Leg, arm and neck braces • Oxygen (includes administration) • Surgical dressings • Casts and splints 	Deductible, then 80%	Deductible, then 60%

Prescription Drugs		In-Network	Out-of-Network
Retail		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)	Generic – 60% coinsurance Formulary Brand – 60% coinsurance Non-Formulary Brand – 60% coinsurance
Mail Order		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)	Mail Order not covered
<p>Maintenance medication prescriptions must be filled through Prime Therapeutics Pharmacy Mail Order at (800) 423-1973 Specialty medication prescriptions must be filled through Triessent Specialty Pharmacy at (888) 216-6710 Find additional information at www.bcbsil.com/accenture under the RX Drugs tab.</p>			
Basic Provisions			
Pre- Notification:	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.		
Transplant Coverage:	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.		
Vision:	Routine vision care and hardware covered through EyeMed at (877) 735-9322.		
Hearing:	One routine hearing exam per calendar year. Unlimited diagnostic exams.		
Other Covered Services:	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 www.bcbsil.com/accenture .		
Preventive Care:	Contact Member Services for preventive care coverage specifics.		
<p><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></p> <p>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 www.bcbsil.com/accenture 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.</p>			

*Updated 01/20/2010