



2012 PPO – Option A500

Health plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL): 1-866-804-0976; or

Health plan administered by UnitedHealthcare (UHC): 1-800-901-1939

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 ¹
Lifetime Benefit Maximum	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Annual Deductible² (Participant Pays) Co-payments are not included in the annual deductible Note: Prescription drug coverage is subject to a separate annual deductible.	<i>If satisfied HealthQuotient (HQ) requirement</i> <ul style="list-style-type: none"> \$500 per person \$1,000 per family³ <i>If did not satisfy HQ requirement</i> <ul style="list-style-type: none"> \$750 per person \$1,250 per family³ (children only) \$1,500 per family³ (spouse or spouse and children) 	<i>If satisfied HQ requirement</i> <ul style="list-style-type: none"> \$1,000 per person \$2,000 per family³ <i>If did not satisfy HQ requirement</i> <ul style="list-style-type: none"> \$1,250 per person \$2,250 per family³ (children only) \$2,500 per family³ (spouse or spouse and children)
Annual Out-of-Pocket Limit (Participant Pays) Includes annual deductible and co-insurance; excludes any charges in excess of Reasonable and Customary ¹ charges and non-participating hospital admission co-payments. This limit can be satisfied with medical and/or behavioral health expenses. Note: Prescription drug coverage is subject to a separate annual out-of-pocket maximum.	<ul style="list-style-type: none"> \$2,500 per person \$5,000 per family 	<ul style="list-style-type: none"> \$5,000 per person \$10,000 per family

Plan's Share vs. Participant's Share

The annual deductible, co-payments and annual out-of-pocket limit are the participant's share to pay. All other percentage "benefits" are amounts the Plan (HealthFlex) pays.

¹ Any and all benefits paid are subject to Reasonable and Customary provisions; 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.

² **Higher Medical Plan Deductible Provisions** (Generally, applicable to individuals participating in HealthFlex before April 1, 2011—more details about the HQ requirement are provided online at www.gbophb.org; click on "HealthFlex/WebMD" and then select "2011 Incentives: Frequently Asked Questions.")

- Effective January 1, 2012, any participant with *individual coverage* who did not complete the HealthQuotient (HQ) health risk assessment between August 1 and September 30, 2011 will be subject to the \$250 higher deductible.
- Effective January 1, 2012, any participant who covers their *dependent child(ren) but not a spouse* and did not complete the HQ between August 1 and September 30, 2011 will be subject to the \$250 higher deductible. Every covered dependent in the family unit will also have the \$250 higher deductible. However, the family deductible will not increase by more than \$250.
- Effective January 1, 2012, any participant with *family coverage (including a spouse)* who did not complete the HQ between August 1 and September 30, 2011 will be subject to the \$250 higher deductible. Every covered dependent in the family unit will also have the \$250 higher deductible. However, the family deductible will not be more than \$500 higher. The same higher deductibles would occur if the participant took the HQ between August 1 and September 30, 2011 but the covered spouse *did not*.

³ The family deductible is the total of all charges applied toward the deductible for the primary participant and their covered dependents. Once this total equals the annual deductible amounts shown, the family deductible has been satisfied for the balance of the plan year.

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit¹
Co-insurance (Plan Pays)	<ul style="list-style-type: none"> • 85% after deductible 	<ul style="list-style-type: none"> • 65% after deductible
Primary Care Physician (PCP) Office Visits Primary care physicians include internists, general practitioners, family practitioners, obstetricians, gynecologists and pediatricians.	<ul style="list-style-type: none"> • \$15 co-payment, then Plan pays 100% 	<ul style="list-style-type: none"> • 65% after deductible
Outpatient Short-Term Rehabilitative Therapy <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech therapy Physical and occupational therapy: combined \$6,000 calendar year maximum. Speech therapy: \$4,000 calendar year maximum.	<ul style="list-style-type: none"> • \$15 co-payment, then Plan pays 100% • \$15 co-payment, then Plan pays 100% • \$15 co-payment, then Plan pays 100% 	<ul style="list-style-type: none"> • 65% after deductible • 65% after deductible • 65% after deductible
Specialist Office Visits	<ul style="list-style-type: none"> • \$40 co-payment, then Plan pays 100% • Allergy injections only: Plan pays 100% 	<ul style="list-style-type: none"> • 65% after deductible • 65% after deductible
Preventive Care⁴ Well Child Benefits (Under age 16) <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 age 2 and older. Well Adult Benefits (16 and Over) <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% • 100% • 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) • 65% after deductible
Licensed Dietitian⁴ Office visit	<ul style="list-style-type: none"> • \$15 co-payment, then Plan pays 100% 	<ul style="list-style-type: none"> • \$15 co-payment, then Plan pays 100%
Outpatient Diagnostic Services and Treatment <ul style="list-style-type: none"> • Physician office • Hospital, independent lab and x-ray facility 	<ul style="list-style-type: none"> • \$15 co-payment if PCP, then Plan pays 100%; \$40 co-payment if specialist, then Plan pays 100% • 85% after deductible 	<ul style="list-style-type: none"> • 65% after deductible • 65% after deductible

⁴ Due to the federal health care reform legislation enacted in 2010, certain preventive services in this benefit category may be paid at a different benefit level. If you wish to know what these services are, contact your medical plan provider (BCBSIL: 1-866-804-0976 or UHC: 1-800-901-1939).

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit ¹
Outpatient Services/Ambulatory Surgery Includes surgery in the physician's office.	<ul style="list-style-type: none"> 85% after deductible 	<ul style="list-style-type: none"> 65% after deductible
Inpatient Hospital Care <i>Pre-notification required. Verify with physician.</i>	<ul style="list-style-type: none"> 85% after deductible 	<ul style="list-style-type: none"> \$200 per admission hospital co-payment, then 65% after Plan deductible
Transplant <i>Pre-notification required. Verify with physician.</i>	<ul style="list-style-type: none"> 85% after deductible at a Blue Distinction Center for Transplant (BCBSIL) or United Resource Network facility (UHC) 	<ul style="list-style-type: none"> Not covered
Emergency Care <i>Notification required within 48 hours if admitted</i> <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 (must be a true emergency as defined in the Plan) 	<ul style="list-style-type: none"> \$15 co-payment per visit, then Plan pays 100% \$40 co-payment per visit, then Plan pays 100% \$200 co-payment* per visit, then Plan pays 100%⁵ \$100 co-payment* per visit, then Plan pays 100%⁵ 85% after deductible <p>* Waived if admitted</p>	<ul style="list-style-type: none"> \$15 co-payment per visit, then Plan pays 100%⁵ \$40 co-payment per visit, then Plan pays 100%⁵ \$200 co-payment* per visit, then Plan pays 100%⁵ \$100 co-payment* per visit, then Plan pays 100%⁵ 85% after deductible <p>* Waived if admitted</p>
Maternity Care/Physician Charges⁴ Enroll during the first trimester for education and support throughout the pregnancy. <ul style="list-style-type: none"> BCBSIL: 1-866-804-0976 UHC: 1-800-901-1939 <i>Pre-notification required. Verify with physician.</i>	<ul style="list-style-type: none"> \$15 co-payment for initial visit to confirm pregnancy 85% after the deductible for all eligible subsequent physician charges for prenatal visits, postnatal visits and delivery 	<ul style="list-style-type: none"> 65% after deductible 65% after the deductible for all eligible subsequent physician charges for prenatal visits, postnatal visits and delivery
Newborn Routine Nursery Inpatient Services⁴	<ul style="list-style-type: none"> 85% 	<ul style="list-style-type: none"> 65% after deductible
Alternative Therapies <ul style="list-style-type: none"> Chiropractic care Massage therapy Acupuncture Naprapathy Combined \$1,000 calendar year maximum.	<ul style="list-style-type: none"> \$15 co-payment, then Plan pays 100% 50% 50% 50% 	<ul style="list-style-type: none"> 50% after deductible 50% 50% 50%

⁵ Only in the case of a "true emergency" as defined in the Plan. If not a true emergency, the benefit is 85% after the deductible for Participating Providers or 65% after the deductible for Non-Participating Providers. In addition to the participant share, you would also be responsible for those charges in excess of the Maximum Allowance, meaning the hospital or provider may bill you for the balance.

Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit ¹
<p>Special Services</p> <ul style="list-style-type: none"> • Skilled Nursing Facility: 120 days maximum per calendar year • Private Duty Nursing: <ul style="list-style-type: none"> - BCBSIL: \$2,000/month maximum - UHC: \$24,000 annual maximum • Home Health Care: 60-visit maximum per calendar year • Hospice <p><i>Pre-notification required. Verify with physician.</i></p>	<ul style="list-style-type: none"> • 85% after deductible • 85% after deductible • 85% after deductible • 85% after deductible 	<ul style="list-style-type: none"> • 65% after deductible • 65% after deductible • 65% after deductible • 65% 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 • \$40 co-payment, then Plan pays 100% 	<ul style="list-style-type: none"> • 50% up to \$500 per ear • 65% after the deductible
<p>Pre-Notification and Medical Management Review BCBSIL: 1-866-804-0976 UHC: 1-800-901-1939</p>	<p>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 for your Claims Administrator on the left.</p>	
<p>Verification of Benefits for Behavioral Health Services Call 1-800-788-5614</p>	<p>To ensure maximum benefits for behavioral health services, please see the United Behavioral Health (UBH) certificate of insurance for information, or call the number on the left.</p>	
<p>Maximum Allowance</p>	<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 BCBSIL or UHC based on Reasonable and Customary amounts.¹</p> <p>Participating Providers, or Network Providers, have signed an agreement with BCBSIL or UHC to accept the Maximum Allowance as payment in full. Participating Providers have agreed not to bill for amounts in excess of the Maximum Allowance.</p> <p>Non-Participating Providers, or Non-Network Providers, have not signed an agreement with BCBSIL or UHC 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 when using a Non-Participating Provider.</p>	

Important Note for Out-of-Area (OOA) Participants:

- **BCBSIL**—In order to receive maximum benefits under the Plan, you must notify BCBSIL to have your provider approved as a Participating Provider before any *non-emergency* services are rendered. However, in the case of a true emergency, you should seek assistance from the closest health care provider; such emergency services will generally be covered if otherwise eligible under the Plan.
- **UHC**—For a description of your benefits, please refer to the applicable corresponding *UHC OOA Benefit Summary* (UHC OOA – Option A500).

If you have any questions about whether you are an OOA participant, please contact the Health Team at 1-800-851-2201.

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.

Please note: Some plan provisions may be subject to change, based on pending provisions of federal health care legislation.