

**Blue Cross and Blue Shield Of Illinois
PPO Benefits Highlight Sheet**

EBC-Southwest Cook County Cooperative for Special Education		
Lifetime Comprehensive Major Medical Coverage	\$2,000,000	
Deductible – separate deductibles for PPO and Non-PPO. Family deductible is on an aggregate basis.	PPO	Non-PPO
	Individual: \$200 Family: \$600	Individual: \$450 Family: \$1,350
Out-of-Pocket Expense (OPX) Limitation The maximum amount of money an individual contributes toward covered medical services during any one calendar year, including the deductible. (Elective MSA copayment, charges in excess of the Scheduled Maximum Allowance and other benefits noted below with an asterisk (*) do not apply to the out-of-pocket limitation.) Family OPX limit is on an aggregate basis.	Individual: \$1,500 Family: \$3,000	Individual: \$3,500 Family: \$7,000
Hospital	PPO	Non-PPO
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 Home Health Care are also paid on the same basis.	85 %	65 %
Outpatient Surgery and Diagnostic Tests Includes X-rays, blood tests, CAT scans, MRIs, annual routine and diagnostic mammograms and PSA tests performed at a hospital.	85 %	65 %
Outpatient Hospital Service Including Radiation and Chemotherapy.	85 %	65 %
Hospital Emergency Medical/Accident Care Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe acute symptoms. If an inpatient admission occurs, MSA must be contacted within two business days or benefits will be reduced.	\$75 copay then 100 %+	\$75 copay then 100 %+
Mental Health and Chemical Dependency Services (Payment for Professional Services will be based on SMA-Schedule of Maximum Allowances)	PPO	Non-PPO
Chemical Dependency Outpatient Chemical Dependency (30 visits/calendar year) Inpatient Chemical Dependency (30 days/calendar year)	85 %* 85 %*	50 %* 65 %*
Mental Health Services Outpatient Mental Health (30 visits/calendar year) Inpatient Mental Health (30 days/calendar year)	85 %* 85 %*	50 %* 65 %*
Are Mental Health and Chemical Dependency combined? Yes		
Serious Mental Illness Services: When services are provided for the following disorders: schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence and panic disorder, benefits will be as follows: Inpatient: limited to 45 days per calendar year Outpatient: limited to 35 visits per calendar year	85% \$20 copay then 100%+	65% 65%
Professional Services (Based on SMA-Schedule of Maximum Allowances)	PPO	Non-PPO
Physician Office Visits	\$20 copay then 100%	65 %
Medical/Surgical Benefits or Inpatient/Outpatient Physician Services Includes radiologist's, anesthesiologist's and surgeon's charges.	85 %	65 %
Well Care Benefits Including physical exams, diagnostic tests and immunizations.	\$20 copay then 100%	65 %
Chiropractic Services Limited to \$1,000 per calendar year	85 %*	65 %*
* Copayments do not apply to any out-of-pocket expense limitation. + Deductible does not apply. Coinsurance amounts, except as otherwise noted, apply to the PPO Out-of-Pocket Expense Limitation. Note: This sheet only highlights the general program. Specific program details are contained in the Master Policy issued to the Group. Effective Date: 7/1/03 Rev: August 17, 2005		

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Independent Lab Services , including diagnostic X-ray and lab	85 %	65 %
Physical, Speech, and Occupational Therapy Maximum \$3,000 per calendar year per therapy	85 %*	65 %*
Other Covered Services		
<ul style="list-style-type: none"> • Ambulance • Durable Medical Equipment and Prosthetics (Rental price covered up to the purchase price) • Blood and blood components • Leg, arm, and neck braces • Private duty nursing* Maximum \$3,000 per month • Temporomandibular Joint Dysfunction (TMJ)* Lifetime Maximum \$2,500 • Oxygen (includes administration) • Surgical dressings • Casts and splints • Vision Exam (1 routine exam per year is allowed - \$20 copay applies) 	85 %	
Prescription Drugs*+		
<p>Drugs paid at 100 % after copay at participating pharmacies for a 30 day supply. Drugs paid at 100 % after copay through home delivery for maintenance drugs for a 90 day supply. Oral contraceptives available through home delivery only at the highest copay. Drugs paid at 75 % after copay at non-participating pharmacy.</p>		<p>\$10 copay generic*+ \$15 copay for formulary brand*+ \$30 copay for nonformulary brand*+</p>
Basic Provisions		
Medical Services Advisory (MSA):	Notification required prior to all elective admissions. Emergency and Obstetric Admissions: Notification required within 2 working days of admittance. If employee elects not to notify MSA Advisor or follow advice given, hospital benefits will be reduced by \$1,000.	
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 MSA.	
Vision:	Subscriber and all covered family members are eligible for substantial discounts on eye examinations, prescription lenses and eyewear at participating vision centers. To find the nearest location, call EyeMed at 1-866- 726-2767.	
Dependent Eligibility:	To age 19. If full-time student, to age 25.	
Coordination of Benefits:	This program coordinates benefits with other group plans.	
Pre-existing Conditions/ Waiting Period:	Standard HIPAA applies.	

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+ Deductible does not apply.

Coinurance amounts, except as otherwise noted, apply to the PPO Out-of-Pocket Expense Limitation.

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