

Publicis Benefits Connection Health Plan Summary 2011

Blue Cross Blue Shield of Illinois

Customer Service: 866-876-1989

	PPO		EPO
BENEFITS	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage Only
Lifetime Comprehensive Major Medical Coverage Maximum:	Unlimited		Unlimited
Deductible: (per individual, per calendar year)	\$250	\$500	None
Family Deductible: (Aggregate)	\$500	\$1,000	None
Individual Out-of-Pocket (OPX): (per individual, per calendar year)	\$2,000	\$4,000	None
Family Out-of-Pocket (OPX): (Aggregate)	\$4,000	\$8,000	None
Out-Of-Pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical services during any one calendar year. This excludes the deductible, co-payments, private duty nursing, prescription drugs, non pre-certification penalty, and charges in excess of the usual and customary.			
Inpatient Hospital Services: (Pre-certification is required. For maternity, a penalty of \$500 applies to the inpatient maternity claim if you do not enroll in the Special Beginnings program within the first trimester of pregnancy.)	90%; subject to deductible	70%; subject to deductible	\$500 copay
Outpatient Surgery & Diagnostic Tests:	90%; subject to deductible	70%; subject to deductible	100%
Outpatient Emergency Medical / Accident Care:	90%	90%	\$50 copay – waived if admitted
Inpatient Mental Health and Chemical Dependency: (Pre-certification is required.)	90%; subject to deductible	70%; subject to deductible	\$500 copay
Outpatient Mental Health and Chemical Dependency:	\$20 copay	70%; subject to deductible	\$30 copay
Medical/Surgical Care:	90%; subject to deductible	70%; subject to deductible	100%
Office Visits:	\$15 copay PCP; \$20 copay Specialist	70%; subject to deductible	\$20 copay PCP \$30 copay Specialist
Wellness Care: Annual physicals for adults; Well child exams covered as defined by standards of American Academy of Pediatrics.	100% deductible does not apply	70%;subject to deductible	100%
Infertility: \$15,000 lifetime maximum for artificial reproduction technology	90%; subject to deductible	70%; subject to deductible	100%
Outpatient Therapies: Physical, Occupational and Speech, limited to 30 visits per therapy per year.	\$20 copay; 100%	70%;subject to deductible	\$30 copay; 100%
Chiropractic Care/Naprapathic Services: \$2,000 maximum per calendar year for muscle manipulation.	\$20 copay; 100%	70%; subject to deductible	\$30 copay; 100%
Other Covered Services: Blood and blood components; ambulance services; oxygen and its administration; surgical dressings, casts and splints; prosthetic devices; and leg, arm, and neck braces.	90%; subject to deductible	70%; subject to deductible	100%
Prescription Drug: Retail is a 34 day supply; Mail Order is a 90 day supply. Mandatory participation in Triessent specialty pharmacy program for Specialty medications. Call (888) 216-6710 to enroll.	Retail Generic: 20% (Min:\$10, Max:\$50) Formulary: 20% (Min:\$20, Max:\$100) Non-Formulary: 20% (Min:\$40, Max:\$200)		Mail Order Generic: 20% (Min:\$25, Max:\$125) Formulary: 20% (Min:\$50, Max:\$250) Non-Formulary: 20% (Min:\$100, Max:\$500)