

Cook County PPO Benefit Plan Highlight Sheet

| | In-Network (Highest Benefit Level) | Out-of-Network (Lower Benefit Level) |
|--|---|---|
| Lifetime Coverage | Unlimited | \$1,000,000 |
| Deductible (per individual, per calendar year) | \$125 | \$250 |
| Family Deductible (family aggregate) | \$250 | \$500 |
| Individual Out-of-Pocket Expense Limitation (the amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit) | \$1,500 | \$3,000 |
| <ul style="list-style-type: none"> • Deductibles • Copayments • Charges that exceed the Eligible Charge or Schedule of Maximum Allowances (SMA) • Services that are asterisked below (*) | | |
| Family Out-of-Pocket Expense Limit (family aggregate) | \$3,000 | \$6,000 |
| Outpatient Surgery and Diagnostic Tests | 90% | 60% [†] |
| Outpatient Emergency (emergency medical and emergency accident) <i>copay waived if admitted to hospital as inpatient</i> | 100% - \$40 copay | 100% [†] - \$40 copay |
| Outpatient Hospital Services | 90% | 60% [†] |
| Inpatient Hospital Services | 90% | 60% [†] |
| Inpatient Mental Health (30 days/year max.*) | 90% | 60% [†] |
| Inpatient Substance Abuse (30 days/year max.*) | 90% | 60% [†] |
| Outpatient Mental Health* | 70% | 50% [†] |
| Outpatient Substance Abuse* | 70% | 50% [†] |
| Chemical Dependency Abuse Max. Limits* | All Chemical Dependency treatment has a maximum benefit of \$5,000 (outpatient) and \$25,000 (combined inpatient and outpatient) per individual, per calendar year, and a \$100,000 lifetime maximum. These limits do <i>not</i> apply to Mental Health services. | |

Additional Services

| | | |
|--|----------------------------------|------------------|
| Outpatient Surgery (physician services) | 90% | 60% [†] |
| Diagnostic Tests (physician services) | 90% | 60% [†] |
| Screening Tests (physician services) | 90% - \$25 copay | 60% [†] |
| Medical/Surgical Benefits | 90% | 60% [†] |
| Physician Office Visits (including adult routine physicals) | 90% - \$25 copay | 60% [†] |
| Maternity Prenatal/Postnatal Visit | 90% - \$25 copay (initial visit) | 60% [†] |
| Child Wellness Care | 90% - \$25 copay | 60% [†] |
| Other Covered Services (services of a registered professional therapist - speech, physical, occupational [60 visits/year max.*], private duty nursing; see Certificate Booklet for other covered services) | 90% | 60% [†] |
| Transplant Coverage | 90% | Not covered |

Basic Provisions

Blue Care Connection (BCC) – formerly known as Medical Services Advisory When members receive covered inpatient hospital services from a participating provider in the state of Illinois, the member will be responsible for contacting the BCC line at (800) 232-3476. When using non-participating Illinois and out-of-state providers, members are required to contact the BCC pre-notification line 1 business day prior to any elective inpatient admission or within 2 business days after an emergency or maternity admission. You must also notify the BCC during the first trimester of pregnancy.

In-Network/Highest Benefit Level Services delivered by in-network PPO providers (no referral required).

Out-of-Network/Lower Benefit Level Services delivered by providers outside the PPO network (no referral required).[†]

[†] Subject to SMA or Eligible Charges, (i.e., the amount doctors and other health care providers in the network have agreed to accept for their services). These amounts are generally lower than what providers outside the network charge. If you go out of the network, you will pay any balance above the SMA in addition to the deductible and coinsurance. The term "Eligible Charges" refers to the amount agreed upon for hospital services.

This provides only highlights of the benefit plan(s). The Certificate Booklet of Coverage will fully describe the benefits of your plan.