General Board of Pension and Health Benefits
of The United Methodist Church

Caring For Those Who Serve

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
1-800-851-2201
www.gbophb.org

2011 PPO – Option B1000

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	• None	• None
Annual Deductible[2] **(Participant Pays)** Co-payments are not included in the annual deductible **Note:** Prescription drug coverage is subject to a separate annual deductible.	*If satisfied HealthQuotient (HQ) requirement* • $1,000 per person • $2,000 per family[3] *If did not satisfy HQ requirement* • $1,250 per person • $2,250 per family[3] (children only) • $2,500 per family[3] (spouse or spouse and children)	*If satisfied HQ requirement* • $2,000 per person • $4,000 per family[3] *If did not satisfy HQ requirement* • $2,250 per person • $4,250 per family[3] (children only) • $4,500 per family[3] (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.	• $4,000 per person • $8,000 per family	• $8,000 per person • $16,000 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, 2010—more details about the HQ requirement are provided online at **www.gbophb.org**; click on "**HealthFlex/WebMD**" and then select "*HealthFlex 2010 Wellness Incentives: Frequently Asked Questions*.")

- Effective January 1, 2011, any participant with *individual coverage* who did not complete the HealthQuotient (HQ) health risk assessment by August 31, 2010 will be subject to the $250 higher deductible.
- Effective January 1, 2011, any participant who covers their *dependent child(ren) but not a spouse* and did not complete the HQ by August 31, 2010 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, 2011, any participant with *family coverage (including a spouse)* who did not complete the HQ by August 31, 2010 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 by August 31, 2010 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.

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Plan Feature	Participating Provider Benefit	Non-Participating Provider Benefit[1]
Co-insurance (Plan Pays)	• 80% after deductible	• 60% after deductible
Primary Care Physician (PCP) Office Visits Primary care physicians include internists, general practitioners, family practitioners, obstetricians, gynecologists and pediatricians.	• $30 co-payment, then Plan pays 100%	• 60% after deductible
Outpatient Short-Term Rehabilitative Therapy • Physical therapy • Occupational therapy • Speech therapy Physical and occupational therapy: combined $6,000 calendar year maximum. Speech therapy: $4,000 calendar year maximum.	• $30 co-payment, then Plan pays 100% • $30 co-payment, then Plan pays 100% • $30 co-payment, then Plan pays 100%	• 60% after deductible • 60% after deductible • 60% after deductible
Specialist Office Visits	• $50 co-payment, then Plan pays 100% • Allergy injections only: Plan pays 100%	• 60% after deductible • 60% after deductible
Preventive Care[4] **Well Child Benefits (Under age 16)** • 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.	• 100%	• 100% up to a $100 calendar year maximum benefit payable for all services (office visits, exams and tests)
Well Adult Benefits (16 and Over) • 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.	• 100%	• 100% up to a $100 calendar year maximum benefit payable for all services (office visits, exams and tests)
• Colonoscopy (Covered once every three years for participants age 45 and older.)	• $100 co-payment, then Plan pays 100%	• 60% after deductible
Licensed Dietitian[4] Office visit	• $30 co-payment, then Plan pays 100%	• $30 co-payment, then Plan pays 100%
Outpatient Diagnostic Services and Treatment • Physician office	• $30 co-payment if PCP, then Plan pays 100%; $50 co-payment if specialist, then Plan pays 100%	• 60% after deductible
• Hospital, independent lab and x-ray facility	• 80% after deductible	• 60% 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.	• 80% after deductible	• 60% after deductible
Inpatient Hospital Care *Pre-notification required. Verify with physician.*	• 80% after deductible	• $200 per admission hospital co-payment, then 60% after Plan deductible
Transplant *Pre-notification required. Verify with physician.*	• 80% after deductible at a Blue Distinction Center for Transplant (BCBSIL) or United Resource Network facility (UHC)	• Not covered
Emergency Care *Notification required within 48 hours if admitted*		
• Primary care physician office visit	• $30 co-payment per visit, then Plan pays 100%	• $30 co-payment per visit, then Plan pays 100%[5]
• Specialist physician office visit	• $50 co-payment per visit, then Plan pays 100%	• $50 co-payment per visit, then Plan pays 100%[5]
• Hospital emergency room	• $50 co-payment*, then Plan pays 100%[5]	• $50 co-payment* per visit, then Plan pays 100%[5]
• Outpatient facility or other urgent care facility	• $50 co-payment*, then Plan pays 100%[5]	• $50 co-payment* per visit, then Plan pays 100%[5]
• Ambulance (must be a true emergency as defined in the Plan)	• 80% after deductible	• 80% after deductible
	* *Waived if admitted*	* *Waived if admitted*
Maternity Care/Physician Charges[4] Enroll during the first trimester for education and support throughout the pregnancy. • BCBSIL: 1-866-804-0976 • UHC: 1-800-901-1939 *Pre-notification required. Verify with physician.*	• $30 co-payment for initial visit to confirm pregnancy • 80% after the deductible for all eligible subsequent physician charges for prenatal visits, postnatal visits and delivery	• 60% after deductible • 60% after the deductible for all eligible subsequent physician charges for prenatal visits, postnatal visits and delivery
Newborn Routine Nursery Inpatient Services[4]	• 80%	• 60% after deductible
Alternative Therapies		
• Chiropractic care	• $30 co-payment, then Plan pays 100%	• 50% after deductible
• Massage therapy	• 50%	• 50%
• Acupuncture	• 50%	• 50%
• Naprapathy	• 50%	• 50%
Combined $1,000 calendar year maximum.		

[5] Only in the case of a "true emergency" as defined in the Plan. If not a true emergency, the benefit is 80% after the deductible for Participating Providers or 60% 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]
Special Services • Skilled Nursing Facility: 120 days maximum per calendar year • Private Duty Nursing: - BCBSIL: $2,000/month maximum - UHC: $24,000 annual maximum • Home Health Care: 60-visit maximum per calendar year • Hospice *Pre-notification required. Verify with physician.*	• 80% after deductible • 80% after deductible • 80% after deductible • 80% after deductible	• 60% after deductible • 60% after deductible • 60% after deductible • 60% after deductible
Hearing Benefit • Hearing aids – Every 24 months • Exam	• 50% up to $500 per ear • $50 co-payment, then Plan pays 100%	• 50% up to $500 per ear • 60% after the deductible
Pre-Notification and Medical Management Review BCBSIL: 1-866-804-0976 UHC: 1-800-901-1939	To ensure maximum benefits, *pre-notification is required* for certain services. Please see the HealthFlex Benefit Booklet for a complete list, or call the number for your Claims Administrator on the left.	
Verification of Benefits for Behavioral Health Services Call 1-800-788-5614	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.	
Maximum Allowance	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] 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. 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.	

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 B1000).

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.