

**BENEFIT HIGHLIGHTS**

**PPO Network**

*This provides only highlights of the benefit plans(s). After enrollment, members will receive a Certificate that more fully describes the terms of coverage.*

**Health Care Account (HCA)**

**Contribution**

<b>Initial HCA Employer Contribution for Individual Coverage</b>	\$750 - effective date: January 1 through June 30 \$375 - effective date: July 1 through December 31
<b>Initial HCA Employer Contribution for Family Coverage</b>	\$1,500 - effective date: January 1 through June 30 \$750 - effective date: July 1 through December 31
<b>Annual HCA Employer Contribution for Individual Coverage</b>	\$750 - every January 1 thereafter
<b>Annual HCA Employer Contribution for Family Coverage</b>	\$1,500 - every January 1 thereafter
<b>Maximum HCA Balance for Individual Coverage</b>	\$1,500
<b>Maximum HCA Balance for Family Coverage</b>	\$3,000

**Program Basics**

**PPO (In-Network)**

**Non-PPO (Out-of-Network)**

<b>Lifetime Benefit Maximum</b> Per individual	\$5,000,000	
<b>Individual Coverage Deductible</b> The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$1,500	
<b>Family Coverage Deductible</b> Satisfied when the total of expenses applied to the deductible reaches the family deductible amount for all covered family members. No individual family member may meet any more than the individual deductible amount. The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$3,000	
<b>Individual Coverage Out-of-Pocket Expense (OPX) Limit</b> 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: <ul style="list-style-type: none"> <li>• Deductibles</li> <li>• Copayments</li> <li>• Reductions in benefits due to non-compliance with utilization management program requirements</li> <li>• Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)</li> <li>• Services that are asterisked below (*)</li> </ul>	\$0	\$1,000
<b>Family Coverage Out-of-Pocket Expense (OPX) Limit</b> Satisfied when the total expenses of all covered family members meet the Family Coverage OPX limit amount. Each family member may not meet more than the Individual Coverage OPX.	\$0	\$2,000

**Prescription Drugs**  
Outpatient prescription drugs may be covered under Other Covered Services below or provided under a drug card program. Please refer to the *Outpatient Prescription Drug Benefit Highlights* and *Three Tier Formulary Prescription Drug Card Benefit Highlights* sheets for detailed information.

**Physician Services**

<b>Physician Office Visits</b> Includes coverage for office charge, diagnostic lab tests and x-ray services other than for routine care. For routine services, please refer to Well Adult Care and Well Child Care below.	100% after deductible	80% after deductible
<b>Well Adult Care (age 16 and over)</b> Coverage for routine office visits including exams and routine diagnostic tests received or ordered on the same day as office visit.	100%	80% after deductible \$500 maximum per calendar year
<b>Well Child Care (to age 16)</b> Coverage for routine office visits including physical exams, immunizations and routine diagnostic tests.	100%	80% after deductible, \$500 maximum per calendar year
<b>Maternity Services</b> First prenatal visit (per pregnancy) and all other maternity physician covered services.	100% after deductible	80% after deductible
<b>Medical / Surgical Services</b> Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	100% after deductible	80% after deductible

**Hospital Services**

<b>Hospital Admission Deductible</b> Per admission, per individual	\$0	\$300
<b>Inpatient Hospital Services</b> Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.	100% after deductible	80% after deductible

20381.0905



**BENEFIT HIGHLIGHTS**

**PPO Network**

**Hospital Services (continued)**

**PPO (In-Network)**

**Non-PPO (Out-of-Network)**

**Outpatient Hospital Services**

Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.

100% after deductible

80% after deductible

**Outpatient Emergency Care (Accident or Illness)**

The deductible and coinsurance applies to both in- and out-of-network emergency room visits.

\$75 copay, then 100% after deductible

**Mental Health & Chemical Dependency**

**Serious Mental Illness Treatment**

- Inpatient: Limited to 45 days per calendar year.
- Outpatient: Limited to 35 visits per calendar year.

**Inpatient:**  
100% after deductible

**Inpatient:**  
\$300 hospital deductible, then 80% after program deductible is met

**Outpatient:**  
100% after deductible

**Outpatient:**  
80% after deductible

**Other Mental Health & Chemical Dependency Treatment Services\***

- Inpatient: Limited to 30 days per calendar year.
- Outpatient: Limited to 30 visits per calendar year. Lifetime maximum 100 visits.

**Inpatient:**  
60% after deductible

**Inpatient:**  
\$300 hospital deductible, then 50% after program deductible is met

**Outpatient:**  
60% after deductible

**Outpatient:**  
50% after deductible

**Additional Services**

**Muscle Manipulation Services\***

Coverage for spinal and muscle manipulation services provided by a physician or chiropractor.

- \$1,000 maximum per calendar year.

100% after deductible

80% after deductible

**Therapy Services – Speech, Occupational and Physical\***

Coverage for services provided by a physician or therapist.

- \$5,000 maximum per therapy per calendar year

100% after deductible

80% after deductible

**Temporomandibular Joint (TMJ) Dysfunction and Related Disorders\***

- \$2,500 lifetime maximum

100% after deductible

80% after deductible

**Other Covered Services**

- Private duty nursing\* - \$3,000 maximum per month
- Naprapathic services\* - \$1,000 maximum per calendar year
- Artificial limbs and other prosthetic devices
- Blood and blood components
- Ambulance services
- Orthotic appliances
- Prosthetic appliances
- Medical supplies

100% after deductible

See paragraph below regarding Schedule of Maximum Allowances (SMA).

\* Does not apply to any out-of-pocket limits

**Durable Medical Equipment (DME)** is a covered benefit. Please refer to Certificate for details.

**Discounts on Eye Exams, Prescription Lenses and Eyewear**

Members present their ID cards for discounts on eye exams, prescription lenses and eyewear at participating vision centers. Call (866) 273-0813 to locate a provider.

**Blue Care Connection (BCC)**

When members receive covered inpatient hospital services, coordinated home care, skilled nursing facility or private duty nursing from a participating provider in the state of Illinois, the member will be responsible for contacting the BCC pre-notification line. When using non-participating Illinois providers 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. Failure to pre-notify with the BCC when required will result in benefits being reduced by \$1,000.

**Schedule of Maximum Allowances (SMA)**

The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. Providers who do not participate in the PPO network are not obligated to accept the SMA as payment in full and may bill for the balance of their actual charge above and beyond the SMA. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

**To Locate a Participating Provider:** Visit our Web site at [www.bcbsil.com/providers](http://www.bcbsil.com/providers) and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.