

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.

Program Basics

PPO
(In-Network)

Non-PPO
(Out-of-Network)

Lifetime Benefit Maximum

Per individual
 The Lifetime Benefit Maximum includes prescription drug benefits. \$1,000,000

Individual Coverage Deductible

Program deductible does **not** apply to services that have a copayment. \$500 \$500

Family Coverage Deductible

The family deductible maximum is equal to three individual deductibles. \$1500 aggregate

Individual Coverage Out-of-Pocket Expense (OPX) Limit

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 \$1,800

- Office Visit Copayments
- Hospital Emergency Room Copayments
- Reductions in benefits due to non-compliance with utilization management program requirements
- Charges for Outpatient Prescription Drug Program
- Mental Health and Chemical Dependency **

** OPX limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and **not** applied against any deductible or copay amount.

Family Coverage Out-of-Pocket Expense (OPX) Limit

\$4,500 \$5,400

Prescription Drug Card (Retail and Mail Service)

Please refer to the *Outpatient Prescription Drug Highlights Sheet* for the covered benefits.

Physician Services

Physician Office Visits

Office Visit Copayment applies to the office visit and all other services provided in the office on same day, except for mental health services. \$20 copay, then 100% 80% after deductible
 Allergy Services are paid at 100% after \$20 copayment if there is no office visit charge billed.

Well Adult Care (age 19 and over)

Coverage for annual physical exam including routine diagnostic test received or ordered on the same day as the physical exam. \$20 copay, then 100% 80% after deductible
 Wellness Services will pay at 100% up to a \$300 individual annual maximum. After the maximum has been met, Wellness Services are subject to deductible and coinsurance.

Well Child Care (to age 19)

Coverage for physical exams, immunizations and routine diagnostic tests. \$20 copay, then 100% 80% after deductible,
 Wellness Services will pay at 100% up to a \$300 individual annual maximum. After the maximum has been met, Wellness Services are subject to deductible and coinsurance.

Maternity Services

Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services. \$20 copay, then 100% 80% after deductible

Medical / Surgical Services

Coverage for surgical procedures, therapies, and certain diagnostic procedures as well as other physician services. 90% after deductible 80% after deductible

Hospital Services

Inpatient Hospital Services

Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. 90% after deductible 80% after deductible
 Room allowances based on the hospital's most common semi-private room rates.

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. 90% after deductible 80% after deductible

Outpatient Emergency Care (Accident or Illness)

The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital. \$50 copay, then 90%
 Non-Emergency use of an Out-of-Network Emergency Room will reduce benefits to 80% after deductible.

BENEFIT HIGHLIGHTS

PPO Network

Mental Health & Chemical Dependency

PPO (In-Network)

Non-PPO (Out-of-Network)

Mental Illness Treatment Services

- Inpatient: Limited to 30 days per calendar year. The 30 day calendar year maximum is combined between Mental Health and Chemical Dependency. The day maximum is also combined between in and out-of-network services.
- Outpatient**: Limited to 52 visits per calendar year (copayment applies if in physician's office). The 52 visit calendar year maximum is combined between Mental Health and Chemical Dependency. The day maximum is also combined between in and out-of-network services.

Inpatient:
90% after deductible

Inpatient:
80% after deductible

Outpatient:
50% after deductible

Outpatient:
50% after deductible

Chemical Dependency Treatment Services*

- Inpatient: Limited to 30 days per calendar year. The 30 day calendar year maximum is combined between Mental Health and Chemical Dependency. The day maximum is also combined between in and out-of-network services.
- Outpatient: Limited to 52 visits per calendar year. The 52 visit calendar year maximum is combined between Mental Health and Chemical Dependency. The day maximum is also combined between in and out-of-network services.

Inpatient:
90% after deductible

Inpatient:
80% after deductible

Outpatient:
50% after deductible

Outpatient:
50% after deductible

Chemical Dependency Lifetime maximum of \$25,000.

Additional Services

Muscle Manipulation Services

Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits.

- \$2,000 maximum per calendar year.

\$20 copay,
then 100%

80% after deductible

Therapy Services – Speech, Occupational and Physical

Coverage for services provided by a physician or therapist.

\$20 copay,
then 100%

80% after deductible

Other Covered Services

- Private duty nursing* - \$10,000 lifetime maximum
- Artificial limbs and other prosthetic devices
- Blood and blood components
- Ambulance services
- Prosthetic/ Orthotic appliances
- Medical supplies

90% after deductible

* Does not apply to the lifetime maximum

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.

To Locate a Participating Provider: Visit our Web site at <http://www.bcbsil.com/dobson> and use our Provider Finder® tool.