

**\$1,000/\$2,000 DEDUCTIBLE - \$20 COPAY**

**E2P83423**

**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

\$5,000,000

**Individual Deductible**

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

\$1,000

\$2,000

**Family Deductible**

The family deductible maximum is equal to three individual deductibles.

3x individual

**Individual 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:

\$2,000

\$4,000

- Deductibles
- Copayments
- Reductions in benefits due to non-compliance with utilization management program requirements
- Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)
- Services that are asterisked below (\*)

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

\$6,000

\$12,000

**Physician Services**

**Physician Office Visits**

One copayment per day when you receive services from a Family Practice, Internal Medicine, OB/GYN, or Pediatrician. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services.

\$20 copay,  
then 100%

60% after deductible

One copayment per day when you receive services from a specialist. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services.

\$40 copay,  
then 100%

60% after deductible

**Well Adult Care (age 16 and over)**

Includes benefits for routine physical examinations, immunizations and routine diagnostic tests.

- Limited to one physical exam plus one gynecological exam per calendar year.

\$20 copay,  
then 100%

60% after deductible  
\$500 maximum per  
calendar year

**Well Child Care (to age 16)**

Coverage for physical exams, immunizations and routine diagnostic tests.

\$20 copay,  
then 100%

60% after deductible,  
\$500 maximum per  
calendar year

**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%

60% after deductible

**Medical / Surgical Services**

Coverage for surgical procedures, inpatient visits therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.

80% after deductible

60% after deductible

**Hospital Services**

**Hospital Admission Deductible**

Per admission, per individual

\$0

\$300

**Inpatient Hospital Services**

Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.

80% after deductible

60% after deductible

**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, including mental health and substance abuse services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.

80% after deductible

60% 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.

\$150 copay,  
then 100%

**BENEFIT HIGHLIGHTS**

**PPO Network**

**Additional Services**

**PPO (In-Network)**

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

<b>Muscle Manipulation Services*</b> 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. • \$1,000 maximum per calendar year.	80% after deductible	60% after deductible
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<b>Therapy Services – Speech, Occupational and Physical*</b> Coverage for services provided by a physician or therapist. • \$5,000 maximum per therapy per calendar year	80% after deductible	60% after deductible
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<b>Temporomandibular Joint (TMJ) Dysfunction and Related Disorders*</b> • \$2,500 lifetime maximum	80% after deductible	60% after deductible
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<b>Other Covered Services</b> <ul style="list-style-type: none"> <li>Private duty nursing* - \$3,000 maximum per month</li> <li>Naprapathic services* - \$1,000 maximum per calendar year</li> <li>Blood and blood components</li> <li>Ambulance services</li> <li>Medical supplies</li> </ul> <i>See paragraph below regarding Schedule of Maximum Allowances (SMA).</i>	80% after deductible	
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**Prescription Drugs**

**Payment Options (Generic / Formulary Brand / Non-Formulary Brand)**

<b>Retail</b> Copayments are for up to a 34-day supply at a contracting retail pharmacy, including diabetic supplies: blood glucose test stripes, lancets, diagnostic agents used with urine testing, glucagon.	\$15/\$30/\$50	
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<b>Mail Service</b> Maintenance medications are available for up to a 90-day supply and are subject to the appropriate copayment amount, including diabetic supplies: blood glucose test stripes, lancets, diagnostic agents used with urine testing, glucagon.	\$30/\$60/\$100	
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<b>Contraceptives</b> Available at retail and mail service at the appropriate copayment level based on drug classification.	As indicated above	
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<b>Self-Injectibles</b> Available at retail and mail service at the appropriate copayment level.	As indicated above	
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Prescription drugs categories are added to the program and are subject to change periodically. To verify which drugs are included in your prescription drug benefit program, contact the Pharmacy Program customer service number, which is located on the back of your ID card. You can also visit the BCBSIL Web site at [www.bcbsil.com](http://www.bcbsil.com) and log on to **Blue Access® for Members** to find additional information.  
\* Does not apply to any out-of-pocket limits

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.  
Optometrists, Orthotic, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

**Discounts on Eye Exams, Prescription Lenses and Eyewear**  
Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into **Blue Access® for Members (BAM)** at [www.bcbsil.com/member](http://www.bcbsil.com/member) and click on the **BlueExtras Discount Program** link.

**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 provider 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.