

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

Initial HCA Employer Contribution for Individual Coverage	\$500 - effective date: January 1 through June 30 \$250 - effective date: July 1 through December 31
Initial HCA Employer Contribution for Family Coverage	\$1,000 - effective date: January 1 through June 30 \$500 - effective date: July 1 through December 31
Annual HCA Employer Contribution for Individual Coverage	\$500 - every January 1 thereafter
Annual HCA Employer Contribution for Family Coverage	\$1,000 - every January 1 thereafter

Program Basics

PPO (In-Network)

Non-PPO (Out-of-Network)

Lifetime Benefit Maximum Per individual	\$5,000,000	
Individual Deductible The first services are applied to the self-pay corridor each calendar year and are paid with the member's own funds. Once the self-pay corridor is satisfied, the remaining deductible is paid from the HCA, provided there is any balance in the account.	\$1,500	
Family Deductible 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 are applied to the self-pay corridor each calendar year and are paid with the member's own funds. Once the self-pay corridor is satisfied, the remaining deductible is paid from the HCA, provided there is any balance in the account.	\$3,000	
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: <ul style="list-style-type: none"> 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 (*) 	\$1,500	\$3,000
Family Out-of-Pocket Expense (OPX) Limit 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.	\$3,000	\$6,000

Physician Services

Physician Office Visits Includes coverage for office charge, diagnostic lab tests and x-ray services other than for routine care, including mental health and substance abuse services. For routine services, please refer to Well Adult Care and Well Child Care below.	80% after deductible	60% after deductible
Well Adult Care (age 16 and over) Includes benefits for routine physical examinations, immunizations and routine diagnostic tests.	100%	60% after deductible \$500 maximum per calendar year
Well Child Care (to age 16) Coverage for routine office visits included physical exams, immunizations and routine diagnostic tests.	100%	60% after deductible, \$500 maximum per calendar year
Maternity Services First prenatal visit (per pregnancy) and all other maternity physician covered services.	80% after deductible	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. Room allowances based on the hospital's most common semi-private room rates.	80% after deductible	60% after deductible

BlueEdge Direct HCA Basic 80/60

\$500 HCA - \$1,500 DEDUCTIBLE - \$1,500 OPX

Plans EPD93615



BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

PPO Network

Hospital Services (continued)

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

80% 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.

80% after deductible

60% 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

80% after deductible

60% after deductible

Temporomandibular Joint (TMJ) Dysfunction and Related Disorders*

- \$2,500 lifetime maximum

80% after deductible

60% after deductible

Other Covered Services

- Private duty nursing* - \$3,000 maximum per month
- Naprapathic services* - \$1,000 maximum per calendar year
- Blood and blood components
- Ambulance services
- Medical supplies

80% after deductible

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

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

Prescription Drug

Benefit

Retail / Mail Service

Benefits are for outpatient prescription drugs.

80%

Contraceptives

80%

Self-Injectibles

80%

Diabetic Supplies

80%

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

Optometrists, Orthotic, Prosthetic, Podiatrists, 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 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 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.

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