BlueEdge HSA 100/80

$2,500/$5,000 EMBEDDED DEDUCTIBLE - $2,500 OPX

Plans EPEC1807

BlueCross BlueShield of Illinois

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 Coverage Deductible*	*$2,500*	*$5,000*
Family Coverage Deductible*	*$5,000*	*$10,000*
Individual Coverage Out-of-Pocket Expense (OPX) Limit The maximum amount of money that any individual will have to pay toward covered health care expenses during any one calendar year, **including the program deductible**. The following items will **not** be applied to the out-of-pocket expense limit: • **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)	*$2,500*	*$10,000*
Family Coverage Out-of-Pocket Expense (OPX) Limit The family OPX limit includes the family deductible amount. Please refer to Certificate for details on how the family OPX limit works.	*$5,000*	*$20,000*
Outpatient Prescription Drugs Please refer to the *Outpatient Prescription Drug Benefit Highlights* sheet for detailed information.	*100% after deductible*	

Physician Services

	PPO (In-Network)	Non-PPO (Out-of-Network)
Well Adult Care (age 16 and over) Includes benefits for routine physical examinations, immunizations and routine diagnostic tests, both hospital and professional services. • Limited to one physical exam plus one gynecological exam per calendar year.	*100%*	*80% after deductible $500 maximum per calendar year*
Well Child Care (to age 16) Coverage for physical exams, immunizations and routine diagnostic tests.	*100%*	*80% after deductible, $500 maximum per calendar year*
Maternity Services	*100% after deductible*	*80% after deductible*
Medical / Surgical Services	*100% after deductible*	*80% after deductible*

Hospital Services

	PPO (In-Network)	Non-PPO (Out-of-Network)
Hospital Admission Deductible Per admission, per individual	*$0*	*$300*
Inpatient Hospital Services Coverage includes pre-admission testing and 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*
Outpatient Hospital Services Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, diagnostic x-rays, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center. For routine services such as mammograms, lab tests and x-rays performed in an outpatient hospital setting, see Well Care benefits.	*100% after deductible*	*80% after deductible*
Outpatient Emergency Care (Accident or Illness)* Each calendar year, the program deductible must be met before benefits will begin under this policy. The coinsurance applies to both in- and out-of-network emergency room visits.	*100% after deductible*	

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BENEFIT HIGHLIGHTS

	PPO Network	
Mental Health& Chemical Dependency	**PPO** (In-Network)	**Non-PPO** (Out-of-Network)
Serious Mental Illness Treatment		
• Inpatient: Limited to 45 days per calendar year.	*Inpatient:* 100% after deductible	*Inpatient:* $300 hospital deductible, then 80% after program deductible is met
• Outpatient: Limited to 60 visits per calendar year.	*Outpatient:* 100% after deductible	*Outpatient:* 80% after deductible
Other Mental Health & Chemical Dependency Treatment Services		
• Inpatient: Limited to 30 days per calendar year.	*Inpatient:* 100% after deductible	*Inpatient:* $300 hospital deductible, then 80% after program deductible is met
• Outpatient: Limited to 30 visits per calendar year. Lifetime maximum 100 visits.	*Outpatient:* 100% after deductible	*Outpatient:* 80% after deductible

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. • $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 • Blood and blood components • Ambulance services • Medical supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	100% after deductible	

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 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 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.

***More on Individual Coverage and Family Coverage Deductibles…**

- If a member has **individual coverage**, each calendar year he/she must satisfy an **individual coverage deductible** before receiving benefits under this policy. The amount of the individual deductible is indicated above on this benefit highlight sheet. After a member has claims for covered services in a calendar year, which exceed this deductible amount, benefits will begin.
- If a member and his/her dependents have **family coverage**, each calendar year they must satisfy the **family coverage deductible** before receiving benefits under this policy. The amount of the family deductible is indicated above on this benefit highlight sheet. If one member's claims for covered services in a calendar year meet his **individual deductible within the family deductible**, his benefits will begin. Once the **family coverage deductible** is met, benefits are available for all covered dependents. That is, for the remainder of the calendar year, no other family member will be required to meet the deductible before receiving benefits.
- **Please note:** The deductible amount may be adjusted based on the cost-of-living adjustments determined under the Internal Revenue Code and rounded to he nearest $50.
- **Also note:** Should the Federal Government adjust the deductible for high deductible plans as defined by the Internal Revenue Service, the deductible amount in the Certificate will be adjusted accordingly.

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.

Outpatient Prescription Drug

100% after deductible

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

Covered under Other Covered Services	Benefit
Retail / Mail Service Benefits are for outpatient prescription drugs.	*100%*
Contraceptives	*100%*
Self-Injectibles	*100%*
Diabetic Supplies	*100%*

These benefits are applicable to the medical plan deductible and out-of-pocket expense limitation.

Contracting versus non-contracting pharmacies
When a Blue Cross and Blue Shield of Illinois ID card with the BlueSCRIPT logo is presented to a contracting pharmacy, the member is responsible for 100% of the discounted amount (discounts are based upon BCBSIL negotiated reimbursement arrangements with contracting pharmacies). The contracting pharmacy will file the drug claim electronically with Blue Cross and the member will be reimbursed subject to the medical plan's deductible and out-of-pocket expense (OPX) limit.

At a non-contracting pharmacy, the charge is not discounted leading to higher drug costs, and higher overall health care costs. Non-contracting pharmacies do no file claims with Blue Cross. At non-contracting pharmacies, the member must pay for prescriptions in full and then file a claim for reimbursement.

Remember, using generic drugs whenever possible may help save money. Ask your health care provider if generics are right for you.

How can I find a contracting pharmacy?
Visit our Web site at www.bcbsil.com to find a contracting pharmacy.

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