BluePrint PPO 80/60

$1,000/$2,000 DEDUCTIBLE - $2,000 OPX - $20 COPAY

Plans BPP83422, BPP83423, BPP83424, BPP83426

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 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: • 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 (*)	*$2,000*	*$4,000*
Family Out-of-Pocket Expense (OPX) Limit		
	$6,000	*$12,000*
Prescription Drug Card (Retail and Mail Service)		
Please refer to the *Three Tier Formulary Prescription Drug Card Benefit Highlight Sheet* for the covered benefits.		
Physician Services		
Physician Office Visits		
One copayment per person per day. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance.	*$20 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. 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. 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.	*$75 copay, then 100%*	

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BENEFIT HIGHLIGHTS

Mental Health& Chemical Dependency	PPO Network: PPO (In-Network)	PPO Network: Non-PPO (Out-of-Network)
Serious Mental Illness Treatment		
• Inpatient: Limited to 45 days per calendar year.	***Inpatient:*** *80% after deductible*	***Inpatient:*** *$300 hospital deductible, then 60% after program deductible is met*
• Outpatient: Limited to 60 visits per calendar year (copayment applies if in physician's office).	***Outpatient:*** *$20 copay, then 100%*	***Outpatient:*** *60% after deductible*
Other Mental Health & Chemical Dependency Treatment Services*		
• Inpatient: Limited to 30 days per calendar year.	***Inpatient:*** *60% after deductible*	***Inpatient:*** *$300 hospital deductible, then 50% after program deductible is met*
• Outpatient: Limited to 30 visits per calendar year. Lifetime maximum 100 visits.	***Outpatient:*** *60% after deductible*	***Outpatient:*** *50% after deductible*

Additional Services	PPO Network: PPO (In-Network)	PPO Network: Non-PPO (Out-of-Network)
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.	*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 *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	*80% after deductible*	

* 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 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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