

# BlueAdvantage Entrepreneur PPO 80/60

**\$2,500/\$5,000 DEDUCTIBLE - \$20 COPAY**

**RPPC3423, RPPC3424, RPPC3426**



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

Unlimited

#### Individual Deductible

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

\$2,500

\$5,000

#### Family Deductible

The family deductible maximum is equal to three individual deductibles.

\$7,500

\$15,000

#### 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:

- 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 Highlights Sheet* for the covered benefits.

### 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.

\$40 copay,  
then 100%

60% after deductible

#### Preventive Care

Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF.

100%

60% after deductible

#### 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%

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## BENEFIT HIGHLIGHTS

### PPO Network

#### Additional Services

PPO  
(In-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.

80% after deductible

60% after deductible

##### Temporomandibular Joint (TMJ) Dysfunction and Related Disorders

80% after deductible

60% after deductible

##### Other Covered Services

- Private duty nursing (Please refer to Certificate for details.)
- Ambulance services
- Naprapathic services\* - \$1,000 maximum per calendar year
- Medical supplies
- Blood and blood components

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](http://www.bcbsil.com/member) and click on the **Blue Extras Discount Program** link.

##### Blue Care Connection (BCC)

When members receive covered inpatient hospital services, outpatient mental health and substance abuse services (MHSA), coordinated home care, skilled nursing facility or private duty nursing from a participating provider, the member will be responsible for contacting either the BCC or MHSA preauthorization line, as applicable. You must call one day prior to any hospital admission and/or outpatient MH/SA service or within 2 business days after an emergency medical or maternity admission. Please refer to your benefit booklet for information regarding benefit reductions based on failure to contact the applicable preauthorization line. **Note: Outpatient MHSA preauthorization is effective for services on or after January 1, 2011 or upon your group plan renewal date in 2011 and thereafter.**

##### 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. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment. "Please refer to your certificate booklet for the definition of Eligible Charge and Maximum Allowance regarding Providers who do not participate in the PPO Network."

**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.

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