

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 Coverage Deductible* | \$2,500 | \$5,000 |
| Family Coverage Deductible* Entire deductible must be met. | \$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: <ul style="list-style-type: none"> • 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) | \$5,000 | \$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. | \$10,000 | \$20,000 |
| Outpatient Prescription Drugs Covered under Other Covered Services below. Please refer to the <i>Outpatient Prescription Drug Benefit Highlights</i> sheet for detailed information. | 80% after deductible | |

Physician Services

| | | |
|--|----------------------|----------------------|
| 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 | 80% after deductible | 60% after deductible |
| Medical / Surgical Services | 80% after deductible | 60% after deductible |

Hospital Services

| | | |
|--|----------------------|----------------------|
| 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, 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, diagnostic x-rays, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. For routine services such as mammograms, lab tests and x-rays performed in an outpatient hospital setting, see Well Care benefits. | 80% after deductible | 60% 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. | 90% after deductible | |

BlueEdge HSA 80/60

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

RPSC3805
NPSC3805



BlueCross BlueShield
of Illinois

BENEFIT HIGHLIGHTS

PPO Network

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

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.)
- 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).

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, 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.**

*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. Once a member's claims for covered services in a calendar year 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. Once the family deductible has been satisfied it will not be necessary for anyone else in the family to meet a deductible in that calendar year. That is, for the remainder of the calendar year, no other family member will be required to meet the deductible before receiving benefits. No one is eligible for benefits under family coverage until the entire family deductible has been satisfied.
- **Please note:** The deductible amount may be adjusted based on the cost-of-living adjustments determined under the Internal Revenue Code and rounded to the 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. 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 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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