

BlueEdge Direct HCA Premier 100/80

\$1,000 HCA - \$1,500 DEDUCTIBLE - \$0 OPX

RPD91137

NPD91137



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.

Health Care Account (HCA)

Contribution

Initial HCA Employer Contribution for Individual Coverage

\$1,000 - effective date: January 1 through June 30
\$500 - effective date: July 1 through December 31

Initial HCA Employer Contribution for Family Coverage

\$2,000 - effective date: January 1 through June 30
\$1,000 - effective date: July 1 through December 31

Annual HCA Employer Contribution for Individual Coverage

\$1,000 - every January 1 thereafter

Annual HCA Employer Contribution for Family Coverage

\$2,000 - every January 1 thereafter

Program Basics

PPO
(In-Network)

Non-PPO
(Out-of-Network)

Lifetime Benefit Maximum

Per individual

Unlimited

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:

- 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 (*)

\$0

\$1,000

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.

\$0

\$2,000

Outpatient Prescription Drugs

Covered under Other Covered Services below. Please refer to the *Outpatient Prescription Drug Benefit Highlights* sheet for detailed information.

100% after deductible

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.

100% after deductible

80% after deductible

Preventive Care

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

100%

80% after deductible

Maternity Services

First prenatal visit (per pregnancy) and all other maternity physician covered services.

100% after deductible

80% 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.

100% after deductible

80% 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.

100% after deductible

80% after deductible

21911NGR.1010

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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 services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.

100% after deductible

80% after deductible

Outpatient Emergency Care (Accident or Illness)

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

\$75 copay,
then 100% 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

100% after deductible

80% after deductible

Therapy Services – Speech, Occupational and Physical

Coverage for services provided by a physician or therapist.

100% after deductible

80% after deductible

Temporomandibular Joint (TMJ) Dysfunction and Related Disorders

100% after deductible

80% 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).

100% 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, 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 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.

21911NGR.1010