**BENEFIT HIGHLIGHTS**

**PPO Network**

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

### Program Basics

<table>
<thead>
<tr>
<th></th>
<th>PPO (In-Network)</th>
<th>Non-PPO (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Benefit Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per individual</td>
<td></td>
<td></td>
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<tr>
<td><strong>Individual Coverage Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program deductible does not apply to services that have a copayment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$350</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td><strong>Family Coverage Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$750</td>
<td>$2,100</td>
<td></td>
</tr>
<tr>
<td><strong>Individual Coverage Out-of-Pocket Expense (OPX) Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount of money that any individual will have to pay toward covered health care and outpatient prescription drug expenses during any one calendar year. The following items will <strong>not</strong> be applied to the out-of-pocket expense limit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reductions in benefits due to non-compliance with utilization management program requirements</td>
<td></td>
<td></td>
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<tr>
<td>Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$6,350</td>
<td>$1,700</td>
<td></td>
</tr>
<tr>
<td><strong>Family Coverage Out-of-Pocket Expense (OPX) Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$12,700</td>
<td>$5,100</td>
<td></td>
</tr>
</tbody>
</table>

### Physician Services

**Physician Office Visits**

- One copayment per person 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.
  - $30 copay, then 100% after deductible
  - 80% after deductible

- One copayment per person 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.
  - $50 copay, then 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% 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 after deductible

**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

**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 copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.

- $100 copay, then 100%
**Participating Provider Option PPO**

### BENEFIT HIG HLIG HTS

#### 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.

- 30 visit maximum per calendar year

<table>
<thead>
<tr>
<th>100% after deductible</th>
<th>80% after deductible</th>
</tr>
</thead>
</table>

### Therapy Services – Speech, Occupational and Physical
Coverage for services provided by a physician or therapist.

<table>
<thead>
<tr>
<th>100% after deductible</th>
<th>80% after deductible</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>100% after deductible</th>
<th>80% after deductible</th>
</tr>
</thead>
</table>

### Other Covered Services

- Private duty nursing (Please refer to Certificate for details)
- Ambulance services
- Naprapathic services - 15 visit maximum per calendar year
- Medical supplies
- Blood and blood components

See paragraph below regarding Schedule of Maximum Allowances (SMA).

<table>
<thead>
<tr>
<th>100% after deductible</th>
<th>80% after deductible</th>
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</thead>
</table>

* Does not apply to any out-of-pocket limits

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**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.

**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.*

**BlueCareConnection**

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.

**Affordable Care Act (ACA)**

The benefits shown comply with the Affordable Care Act (ACA), including the accommodation for the women’s preventive services. Also, as part of ACA, clients will be receiving a Summary of Benefits and Coverage (SBC) for enrollments with effective dates beginning on or after September 23, 2012.

For non-grandfathered health plans, certain women’s preventive services may be covered with no member cost-sharing when such services are furnished by an in-network provider. For a full list of these prescriptions and/or services, please contact the Customer Service number on your ID card.

**This is a general summary of your benefits.** Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document by calling Customer Service, for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan’s limitations and exclusions.