BlueAdvantage Entrepreneur PPO 80/60

$1,500/$3,000 DEDUCTIBLE - $30 COPAY

Plans E2P93432, E2P93433, E2P93434, E2P93436

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.	*$1,500*	*$3,000*
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 Highlights Sheet* for the covered benefits.		

Physician Services	PPO (In-Network)	Non-PPO (Out-of-Network)
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.	*$30 copay, then 100%*	*60% after deductible*
Well Adult Care (age 16 and over) Includes benefits for routine physical examinations, immunizations and routine diagnostic tests, both hospital and professional services. • Limited to one physical exam plus one gynecological exam per calendar year.	*$30 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.	*$30 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.	*$30 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	PPO (In-Network)	Non-PPO (Out-of-Network)
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)	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:* $30 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

Service	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. • $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 present their ID cards for discounts on eye exams, prescription lenses and eyewear at participating vision centers. Call (866) 273-0813 to locate a provider.

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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