

BlueAdvantage Entrepreneur PPO 80/60 (\$500/\$1000 DEDUCTIBLE) - \$20 COPAY



HIGHLIGHT SHEET

Benefits	PPO (In Network)	Non PPO (Out of Network)
Lifetime Benefit	\$5,000,000	
Individual Coverage Deductible The amount you must pay each calendar year before payments begin for covered services.	\$500	\$1000
Family Coverage Deductible The family deductible maximum is equal to three individual deductibles.	\$1500	\$3000
Individual Coverage Out-of-Pocket Expense Limit The maximum 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 noncompliance with utilization management program requirements, charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA) and charges for services asterisked below (*).	\$1000	\$2000
Family Coverage Out-of-Pocket Expense Limit The family out-of-pocket is equal to three individual out-of-pocket expense limits.	\$3000	\$6000
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 rate.	80%	60%
Hospital Admission Deductible The hospital admission deductible is applied per admission, per individual.	\$0	\$300
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 outpatient hospital setting are payable at 100%, no deductible will apply.	80%	60%
Physician Office Visits** One copayment per day; includes office charge, lab and X-ray services, pap smears, digital rectal exams, prostate specific antigen tests and mammograms. For out-of-network coverage, the deductible and coinsurance apply.	\$20 copayment*, then 100%	60%
Well Adult Care (age 16 and over) Coverage for annual adult physical exam including routine diagnostic tests received or ordered on the same day as the physical exam. Limited to one physical exam plus one gynecological exam per calendar year. For out-of-network coverage, the deductible, coinsurance and a \$500 maximum per calendar year apply.	\$20 copayment*, then 100%	60%*
Maternity Services First prenatal visit (per pregnancy) All other Maternity Hospital/Physician Covered Services	\$20 copayment* for 1st prenatal visit 80%	60% 60%
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%	60%

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Well-Child Care (to age 16) Coverage for physical exams, immunizations and routine diagnostic tests. For out-of-network coverage, the deductible, coinsurance and a \$500 maximum per calendar year apply.	\$20 copayment*, then 100%	60%*
Outpatient Emergency Care (Accident or Illness) The copayment applies to both in and out-of-network emergency room visits. The co-payment is waived if the member is admitted. Any surgical procedures, stitches, gluing and castings performed in the emergency room are paid as Medical/Surgical Services.	\$75 copayment*, then 100%†	\$75 copayment**, then 100%†
Serious Mental Illness Treatment When services are provided for the following disorders: schizophrenia, paranoia and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, and panic disorders, benefits will be as follows: Inpatient: Limited to 45 days/calendar year. Outpatient: Limited to 35 visits/calendar year.	Inpatient: 80% Outpatient: \$20 copayment* (if in doctor's office), then 100%	Inpatient: \$300 hospital deductible, 60% Outpatient: 60%
Other Mental Health & Chemical Dependency Treatment Services Inpatient: Inpatient care limited to 30 days/calendar year. Outpatient: Limited to 30 visits/calendar year. Lifetime maximum – 100 visits.	60%*	\$300 hospital deductible, 50%* 50%*
Muscle Manipulation Services Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Limited to a \$1,000* maximum per calendar year. Related office visits are paid the same as other Physician Office Visits.	80%*	60%*
Therapy Services - Speech, Occupational, Physical Coverage for services provided by a physician or therapist. Limited to a \$5,000* maximum per therapy per calendar year.	80%*	60%*
Temporomandibular Joint Dysfunction and Related Disorders Lifetime maximum \$2,500.	80%*	60%*
Other Covered Services Ambulance services; durable medical equipment; private duty nursing (\$1,000* per month maximum); naprapathic services (\$1,000* per calendar year maximum); artificial limbs and other prosthetic devices; oxygen and its administration; blood and blood components; leg, arm and neck braces; surgical dressings; casts and splints. <i>See paragraph below regarding Schedule of Maximum Allowances (SMA).</i>	80%	
Prescription Drug Card (Retail and Home Delivery) See BAE PPO Prescription Drug Highlight Sheet for the covered benefits.		

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

† Deductible does not apply

** Surgeries, therapies, allergy injections/treatments and certain diagnostic procedures performed in an office setting may be subject to the deductible and/or coinsurance.

Discounts on Eye Exams, Prescription Lenses and Eyewear: Members present their ID card for discounts on eye exams, prescription lenses and eyewear at participating vision centers. Call (866) 273-0813 to locate a provider.

Medical Services Advisory (MSA)

When members receive covered inpatient hospital services from a participating provider in the state of Illinois, they will not be responsible for notifying the MSA. When using non-participating Illinois providers and out-of-state providers, members are required to notify the MSA 3 business days prior to any elective inpatient admission or within 1 business day after an emergency or maternity admission. If members fail to notify the MSA when required, benefits will be reduced by \$1,000.

Transplant Coverage: Cornea, kidney, bone marrow, heart valve, heart, lung, heart/lung, pancreas, pancreas/kidney, muscular-skeletal or parathyroid human organ or tissues.

Transplants are paid as any other condition but must have prior procedural approval by the Medical Director, and in addition, facility approval for transplants involving heart, lung, heart/lung, liver, pancreas and pancreas/kidney.

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 a professional service, 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 PPO Provider: Check our web site at www.bcbsil.com/providers to locate a specific PPO provider or to locate a conveniently located PPO provider near you.

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.

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