

Champaign County PPO Plan

\$2,000 Deductible, \$2,000 OPX \$25 OV

Effective January 1, 2018



BlueCross BlueShield of Illinois

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

PPO
(In-Network)

Non-PPO
(Out-of-Network)

Lifetime Benefit Maximum

Per individual

Unlimited

Individual Coverage Deductible

Per calendar year.

\$2,000

\$4,000

Family Coverage Deductible

Per calendar year.

\$4,000

\$8,000

Individual Coverage 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, including the deductible and Rx. The following items will not be applied to the out-of-pocket expense limit:

- Claims for uncovered services
- Preauthorization Penalties
- Charges that exceed the eligible charge

\$2,000

\$4,000

Family Coverage Out-of-Pocket Expense (OPX) Limit

\$4,000

\$8,000

Physician Services

Physician Office Visits

One copayment 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.

\$25 Copay

80% after deductible

Specialist Office Visits

One copayment 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

80% after deductible

Vision Exams

Vision screenings and examinations for determining the refractive state of the eyes are covered. No materials are covered under this benefit.

\$40 Copay

not covered

Preventive Care

Services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). Includes benefits for routine physical examinations, well child care and routine diagnostic tests including, but not limited to: PSA, Pap Smear, Bone Density, and Colonoscopy. Health Education and Counseling services including, but not limited to: Smoking Cessation and Obesity.

100%

80% after deductible

Maternity Services

Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.

\$25 Copay

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

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)

Emergency Medical and Emergency Accident. Applies to both in- and out-of-network emergency room visits. The per-occurrence is waived if the member is admitted to the hospital.

\$200 Copay, then 100% Ambulance Transportation \$100 per transport

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BENEFIT HIGHLIGHT

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.

- Maximum of 30 visits per calendar year

PPO
(In-Network)

Non-PPO
(Out-of-Network)

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)
- Artificial limbs and other prosthetic devices
- Blood and blood components
- Skilled Nursing
- Ambulance services
- Orthotic appliances
- Prosthetic appliances
- Medical supplies

100% after deductible

80% after deductible

Prescription Drug Card

Prescription Drug benefit paid at 100% after co-payment at participating pharmacy. CVS (including CVS inside a Target Store) and Doc's Drugs are not covered pharmacies under this BCBS Plan.

Benefits at a non-contracting pharmacy are covered at 75% of the amount that would have been paid at a contracting pharmacy minus the appropriate copayment amount.

Mail Order Prescription Drug Program – provides up to a 90-day supply of maintenance drugs used on a continuous basis for treatment of chronic health conditions.

- * \$7 copay for generic drugs
- * \$25 copay for preferred brand drugs
- * \$50 copay for non-preferred brand drugs
- * \$100 copay for specialty drugs

Mail Order: 2X retail copay, 90-day supply maintenance drugs (specialty drugs not available thru mail order)

To Locate a Participating Provider: Visit our Web site at www.bcbsil.com/providers and use our Provider Finder® tool. Search the network named Participating Provider Option (PPO).

****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.

Out of network benefits are subject to maximum allowable charge limitations which will limit the amount of charges that will be allowed or considered to be eligible to be paid. This means that generally less than the full amount of the charge will count toward the out of network deductible and less than the full amount of the charge will be covered at the out of network coinsurance limit. Members will be responsible for the differences between the allowed amount and the amount (if any) that the insurance plan will pay.