Champaign County PPO Plan

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

Effective January 1, 2021

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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Additional Services	PPO Network PPO (In-Network)	PPO 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. • *Maximum of 30 visits 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) • 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.