

BluePrint PPO 80/60**\$500/\$1,000 DEDUCTIBLE - \$2,000 OPX - \$20 COPAY****NPP73423, NPP73424, NPP73426**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

Unlimited

Individual DeductibleProgram deductible does **not** apply to services that have a copayment.

\$500

\$1,000

Family Deductible

The family deductible maximum is equal to three individual deductibles.

\$1,500

\$3,000

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 Highlight Sheet* for the covered benefits.**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.

\$20 copay,
then 100%

60% after deductible

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.

\$40 copay,
then 100%

60% after deductible

Preventive Care

Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF.

100%

60% 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.

\$20 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**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, including mental health and substance abuse services. 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, 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.

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.

\$150 copay,
then 100%

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BENEFIT HIGHLIGHTS

Additional Services

PPO Network

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.

80% after deductible

60% after deductible

Temporomandibular Joint (TMJ) Dysfunction and Related Disorders

80% after deductible

60% after deductible

Other Covered Services

- Private duty nursing (Please refer to Certificate for details.)
- 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 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. **Note: Outpatient MHSA preauthorization is effective for services on or after January 1, 2011 or upon your group plan renewal date in 2011 and thereafter.**

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."

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.

Three Tier Formulary Prescription Drug Card

\$15/\$30/\$50 COPAY OPTION



BENEFIT HIGHLIGHTS

Program Basics

Copayment Options (Generic / Preferred / Non-Preferred)

Retail

Copayments are for up to a 34-day supply at a contracting retail pharmacy, including diabetic supplies: blood glucose test strips, diagnostic agents used with urine testing, glucagon.

\$15/\$30/\$50

Mail Service

Maintenance medications are available for up to a 90-day supply and are subject to the appropriate copayment amount, including diabetic supplies: blood glucose test strips, diagnostic agents used with urine testing, glucagon.

\$30/\$60/\$100

Contraceptives

Available at retail and mail service at the appropriate copayment level based on drug classification.

As indicated above

Self-Injectables

Available at retail and mail service at the appropriate copayment level.

As indicated above

Reimbursement for non-contracting pharmacies

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.

Mandatory Specialty Pharmacy Program

Members will be required to obtain covered specialty medications through the Triessent specialty pharmacy program offered by Prime Therapeutics LLC. Members who obtain their covered specialty medication through any contracting pharmacy other than through the Triessent program will be subject to a reduction in benefits.

Prior Authorization and Step Therapy Program Requirements

Your physician may be required to obtain authorization from BCBSIL in order to receive benefits for certain drugs that have a potential for misuse. Examples of these medications include: rheumatoid arthritis, growth hormone, hepatitis C, and anabolic steroids. In the event prior authorization is not obtained, you will be responsible for the first \$1,000 or 50% of the Eligible Charge, whichever is less.

If you are required to receive prior authorization for certain medications under the step therapy program, you need to first try a proven, cost effective medication before progressing to a more costly treatment, if necessary. After a member has a prescription history for a lower-cost alternative medication, coverage will automatically be provided for a more costly medication included in the step therapy program, if the physician and member determine that it is necessary for the member to try a drug included in the program. As an alternative to receiving prior authorization for a drug included in the step therapy program, or paying the entire cost of the drug out-of-pocket, a member along with his/her physician may select another drug, which is not part of the program.

Prescription drugs categories are added to the program and are subject to change periodically. To verify which drugs are included in your prescription drug benefit program, contact the Pharmacy Program customer service number, which is located on the back of your ID card. You can also visit the BCBSIL Web site at www.bcbsil.com and log on to **Blue Access® for Members** to find additional information.

What is the Blue Cross and Blue Shield of Illinois formulary?

The BCBSIL formulary is a regularly updated list of preferred drugs determined by our Pharmacy and Therapeutic Committee, a national panel comprised of individuals who hold a medical or pharmacy degree who evaluate U.S. Food and Drug Administration (FDA)-approved drugs based on comparative clinical standards, including efficacy, safety, uniqueness and cost-effectiveness. The formulary includes all generic drugs and select group of brand drugs. The BCBSIL formulary is "open," meaning that benefits are payable for drugs that are not on the formulary, but are subject to the highest copayment level.

How can I find out if a drug is on the formulary, and if it is a generic or a brand name drug?

As part of the enrollment literature, members may receive a list of some of the most commonly prescribed formulary drugs. If a particular drug does not appear on the list, members can:

- Refer to the pocket edition of the BCBSIL formulary.
- Visit the BCBSIL Web site at www.bcbsil.com.
- Discuss the most appropriate drug therapy with their physician or pharmacist. Using generic drugs whenever possible will help save money.

How can I find a contracting pharmacy?

Visit our Web site at www.bcbsil.com to find a contracting pharmacy.

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