BlueCross BlueShield of Illinois

Legacy Healthcare, LLC

BENEFIT HIGHLIGHTS**

BlueEdge HSA℠ PPO Network

Only highlights of this benefit plan are provided. After enrollment, members will receive a Benefit Booklet that more fully describes the terms of coverage.

Program Basics	PPO (In-Network)	Non–PPO (Out-of-Network)
Individual Coverage Deductible	$5,000	$10,000
Family Coverage Deductible	$10,000	$20,000
Individual Coverage Out-of-Pocket Expense (OPX) Limit The OPX limit is 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: • **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) • **Prescription Drug expenses** are applicable to a separate Pharmacy OPX	$7,050	$13,900
Family Coverage Out-of-Pocket Expense (OPX) Limit	$14,100	$27,800
Outpatient Prescription Drugs Please refer to the Outpatient Prescription Drug Highlight sheet for the covered benefits.	70% after deductible	For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after 50% coinsurance.

Physician Services	PPO (In-Network)	Non–PPO (Out-of-Network)
Physician Office Visits	70% after deductible	50% after deductible
Specialist Office Visits	70% after deductible	50% after deductible
Urgent Care Office Visits Applies for each visit to the physician's office or urgent care facility. For out-of-network services, applies for valid urgent care services only; otherwise benefits will be subject to OON deductible and coinsurance.	70% after deductible	50% after deductible
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%	50% 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.	70% after deductible	50% after deductible
Medical / Surgical Services Coverage for surgical procedures, inpatient visits, therapies and certain diagnostic procedures as well as other physician services.	70% after deductible	50% after deductible

Hospital Services	PPO (In-Network)	Non–PPO (Out-of-Network)
Inpatient Hospital Services Coverage includes pre-admission testing and 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.	70% after deductible	50% after deductible

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Outpatient Hospital Services Coverage for services includes, but is not limited to, outpatient or ambulatory surgical procedures, diagnostic X-rays, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. For routine services such as mammograms, lab tests and X-rays performed in an outpatient hospital setting, see Well Care benefits.	70% after deductible / 50% after deductible
Outpatient Emergency Care (Accident or Illness) Each calendar year, the program deductible must be met before benefits will begin under this policy. The coinsurance applies to both in- and out-of-network emergency room visits.	70% after deductible

Additional Services	PPO (In-Network)	Non–PPO (Out-of-Network)
Muscle Manipulation/Naprapathic 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. • Combined 30 visit maximum per benefit year	70% after deductible	50% after deductible
Therapy Services – Speech, Occupational and Physical Coverage for services provided by a physician or therapist. • Combined 60 visits per benefit year maximum	70% after deductible	50% after deductible
Other Covered Services • Private duty nursing - 120 visit maximum per benefit year • Blood and blood components • Foot Orthotics-2 per benefit period maximum • Ambulance services • Medical supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	70% after deductible	

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotics, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details on these and other provider types.

Discounts on Eye Exams, Prescription Lenses, Eyewear and Other Devices
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 bcbsil.com/member and click on the Blue365® Member Discount Program link.

Wellbeing Management® (WBM)
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 precertifying these services, if applicable.

You must call one day prior to any hospital admission (and/or certain outpatient MH/SA services) 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.

Residential Treatment Centers (RTC) Update
Under the Mental Health Parity and Equity Addiction Act (MHPAEA), residential treatment facilities are now included for the treatment of Mental Health and Substance Abuse conditions. They will be covered at the inpatient hospital facility benefit payment level, per Medical Necessity Criteria, which provides guidelines for level of service, appropriate setting, preauthorization and concurrent review process.

Schedule of Maximum Allowances (SMA)
The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). The 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 bcbsil.com/providers and use our Provider Finder® tool.
Benefits for covered individuals who live outside of Illinois need to meet all extraterritorial requirements of the state they are in, according to the group's funding arrangements.

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** 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 Benefit booklet/Plan document by contacting your Employer. You may also log onto BAM and/or contact Customer Service at the number on the back of your ID card for additional information. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.