Blue Precision HMO

$0 DEDUCTIBLE - $1,500 OPX - $25 COPAY

P501PSN - Blue Precision Platinum HMO 004

BENEFIT HIGHLIGHTS

HMO 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

Benefit	HMO (In-Network)	(Out-of-Network)
Lifetime Benefit Maximum Per individual	Unlimited	
Individual Coverage Deductible Per calendar year.	$0	Not Covered
Family Coverage Deductible Per calendar year.	$0	Not Covered
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**. The following items will **not** be applied to the out-of-pocket expense limit: • Premium • Claims for uncovered services • Preauthorization Penalties • Charges that exceed the eligible charge	$1,500	Not Covered
Family Coverage Out-of-Pocket Expense (OPX) Limit	$4,500	Not Covered

Physician Services

Benefit	HMO (In-Network)	(Out-of-Network)
Physician Office Visits Copayment applies for each visit to the physician's office. Surgeries, therapies, and chiropractic/osteopathic manipulation performed in a physician's office may be subject to the deductible and/or coinsurance. Copay includes lab performed in office, with same date of service.	$25 Copay	Not Covered
Specialist Office Visits Copayment applies for each visit to the physician's office. Surgeries, therapies, and chiropractic/osteopathic manipulation performed in a physician's office may be subject to the deductible and/or coinsurance. Copay includes lab performed in office, with same date of service.	$45 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%	Not Covered
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	Not Covered
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%	Not Covered

Hospital Services

Benefit	HMO (In-Network)	(Out-of-Network)
Hospital Services Per Occurrence Deductible Inpatient Hospitalization / Outpatient Surgery - Per Admission, Per Individual	$150/$100	Not Covered
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. Facility Charge.	100% after deductible	Not Covered
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	Not Covered

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BENEFIT HIGHLIGHTS

	HMO Network	
	HMO (In-Network)	(Out-of-Network)
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.	*$300 per occurrence deductible, then 100% after benefit period deductible*	

Additional Services

Service	HMO (In-Network)	(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 25 visits per calendar year*	*100%*	*Not Covered*
Therapy Services – Speech, Occupational and Physical Coverage for services provided by a physician or therapist.	*100%*	*Not Covered*
Imaging Services (CT, PET scan, MRI)	*100%*	*Not Covered*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders	*100% after deductible*	*Not Covered*
Other Covered Services • Private duty nursing (Please refer to Certificate for details) • Artificial limbs and other prosthetic devices • Blood and blood components – Facility Charges • Infertility Treatment – Facility Charges • Orthotic appliances • Prosthetic appliances • Medical supplies	*100% after deductible*	*Not Covered*
Prescription Drug Card Prescription Drug benefit paid at 100% after co-payment at participating pharmacy. Benefits at a non-contracting pharmacy are covered at 50% of the amount that would have been paid at a contracting pharmacy minus the applicable copayment amount for emergencies only. 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. Member's covered prescription drug expenses will apply to the medical out-of-pocket maximum.	• *$0 copay for preferred generic drugs* • *$10 copay for non-preferred generic drugs* • *$50 copay for preferred brand drugs* • *$100 copay for non-preferred brand drugs* • *$150 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.

****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.