

**BENEFIT HIGHLIGHTS\*\***
**Blue Choice Plan  
[BCS] NETWORK**

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

PLAN DESIGN	In Network	Out of Network
<b>Calendar Year Deductible</b> Embedded/Aggregate Individual Family Deductible Includes Rx	Embedded \$750 \$1,500 N	Embedded \$1,500 \$3,000 N
<b>Out-of-Pocket Maximum</b> Embedded/Aggregate Individual Family Out of Pocket Includes Rx	Embedded \$2,000 \$4,000 Y	Embedded \$6,500 \$13,000 Y
<b>Hospital Services</b> Inpatient Outpatient Emergency Room Urgent Care	\$250 copay per admission 20% after deductible \$150 copay \$50 copay	40% after deductible 40% after deductible \$150 copay 40% after deductible
<b>Outpatient</b> Surgery Diagnostic & Imaging PT/ST/OT limits (60 visits each per calendar year) Chiropractic (60 visits per calendar year)	20% after deductible 20% after deductible \$20 copay \$20 copay	40% after deductible 40% after deductible 40% after deductible 40% after deductible
<b>Physician Office Visits</b> Primary Care Specialist	\$20 copay \$40 copay	40% after deductible 40% after deductible
<b>Wellness/Preventive</b>	100% no deductible	Not covered
<b>Prescription Drugs</b> Rx Network Rx Formulary  <b>Retail &amp; Specialty Rx– 30 day supply</b> Generic Preferred Brand Non-preferred Brand <b>Mail Order – 90 day supply</b> Generic Preferred Brand Non-preferred Brand	Traditional Select Performance Select Drug List	
	\$10 copay \$45 copay \$75 copay  \$25 copay \$112.50 copay \$187.50 copay	50% of allowed cost then copay 50% of allowed cost then copay 50% of allowed cost then copay  Not covered Not covered Not covered
<b>Additional Provisions:</b>	Accredo Specialty dispenses a max 30 day supply	



**Embedded Deductible and Out-of-Pocket** - Once a person meets their Individual deductible, no more deductible is required for that Individual. When the Family deductible is reached, no further deductible will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual deductible amount to the Family deductible amount.

**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)

**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.

**Other Covered Services – General In network payment level** - Private duty nursing, Naprapathic services, Blood and blood components, Ambulance Services Medical Supplies.

**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.

**Outpatient Hospital Services** - Coverage for services includes, but is not limited to, outpatient or ambulatory surgical procedures, 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. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.

**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.

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

**Optometrists, Orthotics, Prosthetic, Podiatrists, 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<sup>SM</sup> (BAM) at [bcbsil.com/member](https://www.bcbsil.com/member) and click on the Blue365<sup>®</sup> Member Discount Program link.

**WellBeing Management**

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.

**To Locate a Participating Provider:** Visit our Web site at <https://www.bcbsil.com> find care and use our Provider Finder<sup>®</sup> 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 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.**