



A Division of Health Care Service Corporation, A Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

300 E. Randolph Street Chicago, IL 60601

1-800-538-8833

SCHEDULE OF BENEFITS

Your **benefits** are highlighted below. However, to fully understand your **benefits**, it is very important that you read this entire **policy**. Although you can go to the **hospital** or **provider** of your choice, **benefits** under this **policy** will be greater when you use the services of a network **provider**. Your **deductible** applies to all **benefits** described below, unless otherwise stated.

Deductible:	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	\$500	\$1,000

Out-of-Pocket Maximum:	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	\$8,150	\$16,300
Per Family per Benefit Period:	\$16,300	\$32,600

Prior Authorization Penalty:	Network Provider	Out-of-Network Provider
Penalty for failure to obtain Prior Authorization for Inpatient admissions or other services needing Prior Authorization as shown in the Prior Authorization Requirements section of this Policy.	\$500	\$500

Covered Expenses	Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	50% of Allowable Amount
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount
- Remaining Eligible Procedures	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount
Substance Use Disorder	20% of Allowable Amount	50% of Allowable Amount

Outpatient Expenses		
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount
- Remaining Eligible Procedures	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Day Surgery/Outpatient Surgical Expenses	20% of Allowable Amount	50% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount
Substance Use Disorder	20% of Allowable Amount	50% of Allowable Amount
Emergency Room		
Accidents and Emergency Care (including Accidents, and Emergency Care and Non-Emergency Care for Behavioral Health Services)		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount \$300 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	
Physician Charges	20% of Allowable Amount	
Diagnostic X-Ray and Laboratory Services	20% of Allowable Amount	
Emergency Room		
Non-Emergency Care		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount \$300 Copayment	
Physician Charges	20% of Allowable Amount	20% of Allowable Amount
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	20% of Allowable Amount
Other Expenses		
Ground and Air Ambulance Transportation**	20% of Allowable Amount	
Urgent Care	\$50 Copayment Deductible Waived	50% of Allowable Amount \$30 Copayment Deductible Waived
Preventive Care Services	No Charge	50% of Allowable Amount
Routine Well-Baby Care	No Charge	50% of Allowable Amount
Routine Pediatric Hearing Examinations	No Charge	50% of Allowable Amount
Office Visits Including Office Visits for Behavioral Health Services	\$30 Copayment Deductible Waived	50% of Allowable Amount \$30 Copayment Deductible Waived
Specialist Office Visits	\$30 Copayment Deductible Waived	50% of Allowable Amount \$30 Copayment Deductible Waived
Telehealth Visits Including Telehealth Visits for Behavioral Health Services	\$30 Copayment Deductible Waived	50% of Allowable Amount \$30 Copayment Deductible Waived

Specialist Telehealth Visits Including Specialist Telehealth Visits for Behavioral Health Services	\$30 Copayment Deductible Waived	50% of Allowable Amount \$30 Copayment Deductible Waived
Radiation and Chemotherapy Services	20% of Allowable Amount	50% of Allowable Amount
Allergy Testing and Allergy Injections (Copayment and/or Coinsurance may apply if billed in the office)	20% of Allowable Amount	50% of Allowable Amount
Chiropractic and Osteopathic Manipulation Benefits will be limited to 25 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Additional Surgical Opinion	20% of Allowable Amount	50% of Allowable Amount
Autism Spectrum Disorder Visit limitations are not Applicable to treatment of Autism and Autism Spectrum Disorders	20% of Allowable Amount	50% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	50% of Allowable Amount
Orthotic Devices Benefits will be limited to 2 orthotic devices or 1 pair of foot orthotic devices per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Habilitative Services and Devices	20% of Allowable Amount \$30 Copayment	50% of Allowable Amount \$30 Copayment
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	
Tests and Procedures	20% of Allowable Amount	50% of Allowable Amount
Blood and Blood Components	20% of Allowable Amount	50% of Allowable Amount
Naprapathic Services Benefits will be limited to 15 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Bariatric Surgery	20% of Allowable Amount	50% of Allowable Amount
Organ and Tissue Transplants	20% of Allowable Amount	50% of Allowable Amount
Injections – when administered in the Doctor’s Office and charged on the Doctor’s statement Deductible Waived	20% of Allowable Amount	50% of Allowable Amount
Abortion Services	20% of Allowable Amount	50% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Coordinated Home Health Care No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Hospice Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Private Duty Nursing Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Cardiac Rehabilitation Services Benefits will be limited to 36 visits per Benefit Period	20% of Allowable Amount \$30 Copayment	50% of Allowable Amount \$30 Copayment
Pulmonary Rehabilitation Therapy	20% of Allowable Amount \$30 Copayment	50% of Allowable Amount \$30 Copayment

Needlestick – Only for Students doing course work or Hospital training	No Charge
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The **copayment** and **coinsurance** amounts mentioned above are subject to change or increase as permissible by **applicable law**.

* You will be responsible for the difference between the **allowable amount** and the billed charges, when receiving **covered services** from an **out-of-network provider**. For questions concerning **out-of-network providers**, please call Blue Cross and Blue Shield of Illinois Customer Service at the toll-free telephone number on the back of your **identification card**.

** Notwithstanding anything else described herein, **providers of ambulance transportation** will be paid based on the amount that represents the billed charges from the majority of the ambulance **providers** in the Chicago metro area, as submitted to Blue Cross and Blue Shield of Illinois.

SCHEDULE OF BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS

Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication:

- Severe allergic reactions
- Hypoglycemia
- Opioid overdoses
- Nitrates

For further information, call the toll-free telephone number on the back of your **identification card**.

Retail Pharmacy Benefit

Retail Pharmacy:	Participating Pharmacies Covered Person Pays	Non-Participating Pharmacies Covered Person Pays**
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	\$15 Copayment	50% of Allowable Amount \$15 Copayment
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	\$15 Copayment	50% of Allowable Amount \$15 Copayment
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35 when obtained from a Participating Pharmacy.	\$35 Copayment	50% of Allowable Amount \$35 Copayment
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35 when obtained from a Participating Pharmacy.	\$50 Copayment	50% of Allowable Amount \$50 Copayment
Preferred Specialty Drugs	N/A	N/A
Non-Preferred Specialty Drugs	N/A	N/A

* One prescription means up to a 30 day supply of a drug (except for certain drugs).

You can purchase a 90-day supply for 3 times the schedule amount listed above.

** **Non-participating pharmacies:** When you obtain **prescription drugs**, including diabetic supplies from a **non-participating pharmacy**, **benefits** will be provided at 50% of the amount you would have received had you obtained drugs from a network **pharmacy** minus the **copayment** amount or **coinsurance** amount.

Mail Order Prescription Drug Program

Mail Order Pharmacy Benefit*:	Mail Order Pharmacy Covered Person Pays
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	\$45 per prescription
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	\$45 per prescription
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	\$105 per prescription
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	\$150 per prescription
Preferred Specialty Drugs	N/A
Non-preferred Specialty Drugs	N/A

Specialty Pharmacy Benefit

Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan **benefits**. Cost-share will be based on the day supply dispensed, (1-30 day supply; 31-60 day supply; 61-90 day supply).

Specialty Pharmacy Benefit*:	Specialty Pharmacy Covered Person Pays
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35 when obtained from a Participating Pharmacy.	N/A
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35 when obtained from a Participating Pharmacy.	N/A
Preferred Specialty Drugs	Same as Retail
Non-Preferred Specialty Drugs	Same as Retail

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

Only for Covered Persons under the age of 19

Vision Care Services	EyeMed Provider Benefit	Non-Contracting Provider Reimbursement Amount
Exam (with dilation as necessary):	No Copayment	Up to \$30
Frames:		
Any available frame at provider location	No Copayment on provider-designated frame \$150 allowance on non-provider designated frame 20% off balance over \$150	Up to \$75
Standard Plastic Lenses:		
Single Vision	No Copayment	Up to \$25
Bifocal	No Copayment	Up to \$40
Trifocal	No Copayment	Up to \$55
Lenticular	No Copayment	Up to \$55
Lens Options:		
UV Treatment	No Copayment	Up to \$12
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	Up to \$12
Standard Plastic Scratch Coating	No Copayment	Up to \$12
Standard Polycarbonate	No Copayment	Up to \$32
Glass	No Copayment	Up to \$12
Oversized	No Copayment	N/A
Photochromic / Transitions Plastic	No Copayment	Up to \$57
Contact Lenses: (Contact Lens allowance includes materials only)		
Conventional	1 pair from selection of provider designated contact lenses	Up to \$150
Disposable	Up to 3 month supply of daily disposable, single vision spherical contact lenses	Up to \$150



BlueCross BlueShield of Illinois

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Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.



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中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłt'ígogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólq. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóo bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hólq. Kohji' 855-710-6984 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í' hanidzihih.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libheng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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