BlueCross BlueShield of Illinois

Blue Choice Preferred Silver PPO℠ 103 - Three $0 PCP Visits

Coverage Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms/2016/36096IL0990003-00.pdf or by calling 1-800-538-8833.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$3,250** Non-Participating **$15,000** Family: Participating **$9,750** Non-Participating **$45,000** Doesn't apply to preventive care & certain copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$6,850** Non-Participating **Unlimited** Family: Participating **$13,700** Non-Participating **Unlimited**	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-538-8833** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-538-8833** or visit us at www.bcbsil.com/coverage.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
SBC IL Non-HMO IND-2016

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- The plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	First 3 visits are no charge. No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Acupuncture not covered. Chiropractic and Osteopathic Manipulation are limited to 25 visits per calendar year.
	Preventive care/screening/immunization	No Charge	50% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_IL_5T_EX.pdf	Formulary generic drugs	$0/$5 copayment/ prescription $0 Home Delivery	$5 copayment/ prescription	Lower copayment applies at preferred participating pharmacies. Retail covers a 30 day supply and home delivery covers a 90 day supply. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. Non-Participating home delivery is not covered. Non-Participating specialty drug coverage is limited to certain medications that are clarified in the prescription drug rider. For Non-Participating drug provider, you are responsible for 50% of the eligible amount after the copayment. Payment of the differenct between the ost of a brand name drug and a generic may be required if a generic drug is available.
	Non-formulary generic drugs	$10/$15 copayment/ prescription $30 Home Delivery	$15 copayment/ prescription	
	Formulary brand drugs	$50/$60 copayment/ prescription $150 Home Delivery	$60 copayment/ prescription	
	Non-formulary brand drugs	$100/$110 copayment/ prescription $300 Home Delivery	$110 copayment/ prescription	
	Specialty drugs	30% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copayment/visit plus 20% coinsurance	$1,500 copayment/ visit plus 50% coinsurance	Abortions not covered, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$600 copayment/visit plus 20% coinsurance	$600 copayment/visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$75 copayment/visit	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copayment/visit plus 20% coinsurance	$1,500 copayment/ visit plus 50% coinsurance	Inpatient Services: Participating (Par), member may be balance billed if preauthorization not received within 15 days prior. Non-Participating (Non-Par), $500 penalty if not preauthorized 2 business days prior.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge/office visits or 20% coinsurance	50% coinsurance	Pre-authorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. Inpatient Services: Par, member may be balance billed if preauthorization not received within 15 days prior. Non-Par, $500 penalty if not preauthorized 2 business days prior. Outpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior.
	Mental/Behavioral health inpatient services	$400 copayment/visit plus 20% coinsurance	$1,500 copayment/ visit plus 50% coinsurance	
	Substance use disorder outpatient services	No Charge/office visits or 20% coinsurance	50% coinsurance	
	Substance use disorder inpatient services	$400 copayment/visit plus 20% coinsurance	$1,500 copayment/ visit plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	---none---
	Delivery and all inpatient services	$400 copayment/visit plus 20% coinsurance	$1,500 copayment/ visit plus 50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Inpatient Services: Par, member may be balance billed if preauthorization not received within 15 days prior. Non-Par, $500 penalty if not preauthorized 2 business days prior. Outpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior.
	Rehabilitation services	20% coinsurance	50% coinsurance	
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	
	Durable medical equipment	20% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	20% coinsurance	50% coinsurance	Inpatient Services: Par, member may be balance billed if preauthorization not received within 15 days prior. Non-Par, $500 penalty if not preauthorized 2 business days prior.
If your child needs dental or eye care	Eye exam	No Charge	Covered	One visit per year. Reimbursed up to $30 out-of-network. See benefit booklet for network details.
	Glasses	Covered	Covered	One pair of glasses per year. Reimbursed up to $45 out-of-network. See benefit booklet for network details.
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)
• Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed) • Acupuncture • Dental Care (Adult) • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
• Bariatric surgery • Chiropractic care (Limited to 25 visits per calendar year.) • Cosmetic surgery (Only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) • Hearing aids (Two covered every 36 months for children or bone anchored) • Infertility treatment • Private-duty nursing (With the exception of inpatient private duty nursing) • Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-538-8833. You may also contact your state insurance department at 1-877-527-9431.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-538-8833.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-538-8833.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-538-8833.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-538-8833.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,940
- **Patient pays** $4,600

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,700
Copays	$0
Coinsurance	$700
Limits or exclusions	$200
Total	**$4,600**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,480**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of Illinois

MAJOR MEDICAL EXPENSE COVERAGE
Blue Choice Preferred Silver PPO℠ 103
Blue Choice Preferred PPO℠ Network

OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. – This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Blue Choice Preferred PPO℠ Coverage – Coverage is designed to provide you with economic incentives for using designated health care providers. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your benefits under the Policy will be greater when you use the services of designated Hospitals and Physicians.**

3. Each benefit period you must satisfy the calendar year Deductible before your benefits will begin, except for Preventive Care Services and other Covered Services not subject to a Deductible. Expenses incurred by you for Covered Services will also be applied towards the calendar year Deductible. Refer to the Policy for more information.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

BASIC PROVISIONS	**Blue Choice Preferred Silver PPO℠ 103**	
	YOUR COST	
Hospitals Benefits Daily bed, board and general nursing care, and ancillary services (i.e., operating rooms, drugs, surgical dressings, and lab work).		
Inpatient Hospital Covered Services	Participating	20% of the Eligible Charge
	Non-Participating	50% of the Eligible Charge

Outpatient Hospital Covered Services Surgery, diagnostic services, radiation, therapy, chemotherapy, electroconvulsive therapy, renal dialysis treatments and continuous ambulatory peritoneal dialysis treatment, coordinated home care program, pre-admission testing, partial hospitalization treatment program, autism spectrum disorders, habilitative services, surgical implants, maternity services, and urgent care.	Participating	20% of the Eligible Charge
	Non-Participating	50% of the Eligible Charge
Urgent Care Facility visits from a Participating Provider	$75 per visit, no Deductible	
Hospital Emergency Care		
Emergency Accident Care from either a Participating or Non-Participating Provider	20% of the Eligible Charge	
Emergency Medical Care from either a Participating or Non-Participating Provider	20% of the Eligible Charge	
Emergency Room Deductible (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	$600 per visit	
Physician Benefits Surgery, anesthesia, assistant surgeon, medical care, treatment of illness, consultations, mammograms, outpatient periodic health examinations, routine pediatric care, diagnostic services, injected medicines, amino acid-based elemental formulas, electroconvulsive therapy, radiation therapy, chemotherapy, cancer medications, outpatient rehabilitative therapy, autism spectrum disorders, habilitative services, outpatient respiratory therapy, chiropractic and osteopathic manipulation, hearing screening, diabetes self-management training and education, pediatric vision care, dental accident care, family planning services, outpatient contraceptive services, bone mass measurement and osteoporosis, investigational cancer treatment, infertility treatment, pediatric dental services, mastectomy related services, maternity services, and urgent care.		
Payment level for Surgical/Medical Covered Services	Participating	20% of the Maximum Allowance
	Non-Participating	50% of the Maximum Allowance
Outpatient office visits (Participating Providers) *(except for Outpatient periodic health examinations, routine pediatric care, pediatric routine vision examinations, Physical Therapy, Occupational Therapy, Speech Therapy, chiropractic and osteopathic manipulation, Surgery, Diagnostic Services (including, x-rays, lab services, CT, PET, MRI) and Maternity Services after the first pre-natal visit)*	No charge for first three visits, then 20% of the Maximum Allowance	
Outpatient Specialist office visits (Participating Providers)	20% of the Maximum Allowance	

Chiropractic and Osteopathic Manipulation	25 Visit Maximum per Benefit Period	
Naprapathic Services	15 Visit Maximum per Benefit Period	
Emergency Accident Care from either a Participating or Non-Participating Provider	20% of the Maximum Allowance	
Emergency Medical Care from either a Participating or Non-Participating Provider	20% of the Maximum Allowance	
Other (Miscellaneous) Covered Services Blood and blood components; medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	20% of Eligible Charge, Ambulance Eligible Charge or Maximum Allowance	
Individual Deductible Per individual, per calendar year. (If you have Family Coverage, each member of your family must satisfy his/her own individual deductible.)	Participating	$3,250*
	Non-Participating	$15,000*
Family Deductible If you have Family Coverage and your family has satisfied the family Deductible amount specified, it will not be necessary for anyone else in your family to meet a calendar year Deductible in the benefit period. That is, for the remainder of that benefit period, no other family members will be required to meet the calendar year Deductible before receiving benefits.	Participating	$9,750*
	Non-Participating	$45,000*
Individual Out-of-Pocket Expense Limit*	Participating	$6,850*
	Non-Participating	No limit*
Family Out-of-Pocket Expense Limit*	Participating	$13,700*
	Non-Participating	No limit*
Inpatient Hospital Deductible	Participating	$400 per admission*
	Non-Participating	$1,500 per admission*

Outpatient Surgical Deductible	Participating	$300 per admission*
	Non-Participating	$1,500 per admission*
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, Deductible, Copayment or dollar maximum: Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	None	

*The calendar year Deductible, Copayment amount, Out-of-Pocket Expense Limit and Covered Service Expense Limitation amounts may be subject to change or increase as permitted by applicable law.

PREFERRED PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and syringes	$0 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	$10 per prescription
Formulary Brand Name Drugs and Formulary Brand name Diabetic Supplies and insulin and insulin syringes	$50 per prescription
Non-Formulary Brand-Name Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	$100 per prescription
Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$100, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
Specialty Drugs	70% of the Eligible Charge per prescription

PARTICIPATING PHARMACY OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and syringes	$5 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	$15 per prescription
Formulary Brand Name Drugs and Formulary Brand name Diabetic Supplies and insulin and insulin syringes	$60 per prescription
Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	$110 per prescription
Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$110, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
Specialty Drugs	70% of the Eligible Charge per prescription

HOME DELIVERY PRESCRIPTION DRUG PROGRAM	
Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and syringes	$0 per prescription
Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes	$30 per prescription
Formulary Brand Name Drugs and Formulary Brand name Diabetic Supplies and insulin and insulin syringes	$150 per prescription
Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available	$300 per Prescription
Non-Formulary Brand-Name Brand Drugs and Non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$300, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription

Schedule of Pediatric Vision Coverage

Vision Care Services	**In-network Covered Person Cost or Discount** (When a fixed-dollar Copayment is due from the Covered Person, the remainder is payable under this Policy up to the covered charge*)	**Out-of-network Allowance** (Maximum amount payable under this Policy, not to exceed the retail costs)**
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
“Collection” frame Frames covered under this Policy are limited to the Pediatric Frame Selection of covered frames. The Pediatric Frame Selection includes a selection of frame sizes (including adult sizes) for children up to age 19. The network provider will show you the selection of frames covered under this Policy. If you select a frame that is not included in the Pediatric Frame Selection covered under this Policy, you are responsible for the difference in cost between the In network provider reimbursement amount for covered frames from the Pediatric Frame Selection and the retail price of the frame selected. If frames are provided by an out-of-network Provider, benefits are limited to the amount shown above. Any amount 1) paid to the in network provider for the difference in cost of a non-Pediatric Frame Selection frame or 2) that exceeds the Maximum Covered Fee for an out-of-network provider supplied frame will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum/out-of-pocket Coinsurance maximum.	No Copayment	Up to $30
Frequency: Examination, Lenses or Contact Lenses Frame	 Once every 12-month benefit period Once every 12-month benefit period	
Standards Plastic, Glass or Poly Spectacle Lenses: Single Vision Lined Bifocal Lined Trifocal Lenticular Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam’s Club	 No Copayment No Copayment No Copayment No Copayment	 Up to $25 Up to $35 Up to $45 Up to $45

Lens Options (add to lens costs above): Ultraviolet Protective Coating Polycarbonate Lenses Blended Segment Lenses Intermediate vision Lenses Standard Progressives Premium Progressives (Varilux®, etc.) Photochromic Glass Lenses Plastic Photosensitive Lenses (Transitions®) Polarized Lenses Standard Anti-Reflective (AR) Coating Premium AR Coating Ultra AR Coating High Index Lenses Progressive Lens Options – Members may receive a discount on additional progressive lens options: Select Progressive Lenses Ultra Progressive Lenses Scratch Protection Plan Single Vision Lens Multifocal Lens	 No Copayment No Copayment $20 Copayment $30 Copayment No Copayment $90 Copayment $20 Copayment No Copayment $75 Copayment $35 Copayment $48 Copayment $60 Copayment $55 Copayment $70 Copayment $195 Copayment $20 Copayment $40 Copayment	Not covered
Contact Lenses: covered once every calendar year – in lieu of eyeglasses Elective Medically Necessary contact lenses – Preauthorization is required to be considered for benefits (see details below) Contact lenses covered under this Policy are limited to the Pediatric Lens Selection. The Network Provider will inform you of the contact lens selection covered under this Policy. If you select a frame that is not included in the pediatric lens selection covered under this Policy, you are responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Selection and the retail price of the contact lenses selected. Any amount 1) paid to the network provider for the difference in cost of a non-Pediatric Contact Lens Selection contact lens or 2) that exceeds the Maximum Covered Fee for Non-Participating Provider supplied contacts will not apply to any applicable Deductible, Coinsurance, or out-of-pocket maximum/out-of-pocket limit/out-of-pocket coinsurance maximum. Note: Additional benefits over allowance are available from participating providers except	 Maximum of 2 boxes per calendar year Maximum of 2 boxes per calendar year	 Up to $75 Up to $225

Walmart and Sam's Club		

Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

Value-added features:
Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK from Participating Physicians and contracted laser centers. You must obtain Preauthorization for this service in order to receive coverage. Prices/discounts may vary by state and are subject to change without notice.
Mail-order contact lens replacement: Lens 1-2-3® Program (visit the Lens 1-2-3 website: www.lens123.com).

Additional Benefits

Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are covered in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision.

With prior approval from Blue Cross and Blue Shield of Illinois, covered persons who required low-vision services and optical devices are entitled to the following coverage, both In- and Out-of Network:

Low Vision Evaluation: One comprehensive evaluation every five years (Out-of-Network Maximum Allowance of $300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

Low Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers and telescopes (Out-of-Network Maximum Allowance of $600 per device and $1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's vision goals and lifestyle needs.

Follow-up care: Four visits in any five-year period (Out-of-Network Maximum Allowance of $100 per visit).

Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* The "covered charge" is the rate negotiated with network providers for a particular Covered Service.

**** THE PLAN PAYS THE LESSER OF THE MAXIMUM ALLOWANCE NOTED OR THE RETAIL COST. RETAIL PRICES VARY BY LOCATION.**

EXCLUSIONS AND LIMITATIONS:

Services or supplies that are not specifically mentioned in this Policy.

Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

Services or supplies that do not meet accepted standards of medical and/or dental practice.

Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Policy for a) Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Service.

Respite Care Service, except as specifically mentioned under the Hospice Care Program section of this Policy.

Inpatient Private Duty Nursing.

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions.).

Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Special braces, specialized equipment, appliances, or ambulatory apparatus, except as specifically mentioned in this Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Eyeglasses, contact lenses or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy. This is exclusion is not applicable to children.

Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care.

Routine foot care, except for persons diagnosed with diabetes.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy.

Acupuncture, whether for medical or anesthesia purposes.

Maintenance Care.

Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Policy. This exclusion is not applicable to children as described in this Policy.

Diagnostic Service as part of determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy.

Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, for the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

Wigs (also referred to as cranial prostheses).

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically mentioned in this Policy.

Reversals of vasectomies.

Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness except as specifically mentioned under this Policy.

Any drugs and medicines, except as may be provided under Outpatient Prescription Drugs, that are:

- Dispensed by a Pharmacy and received by you while covered under this Policy,
- Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by you for use on an Outpatient basis,
- Over-the-counter drugs and medicines; or drugs for which no charge is made,
- Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations,
- Retin-A or pharmacological similar topical drugs.

Abortions for which Federal funding is not allowed in accordance with Affordable Care Act section 1303(b)(1)(B)(i), namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Policy.

Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

Not withstanding any provision in the Policy to the contrary, any services and/or supplies provided to you outside the United States, unless you receive Emergency Accident Care or Emergency Medical Care.

GUARANTEED RENEWABILITY

Coverage under the Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew the Policy only for the following reasons:

1. If every Policy that bears the Policy form number, is not renewed. If every Policy that bears the same Group Number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate the Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinue all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of the Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice.
4. You no longer reside, live or work in the Blue Cross and Blue Shield’s service area.
5. Failure to pay your premium in accordance with the terms of the Policy, including any timeliness requirements.

Blue Cross and Blue Shield will never terminate or refuse to renew the Policy because of the condition of your health.