BlueCross BlueShield of Illinois

MAJOR MEDICAL EXPENSE COVERAGE
Blue Choice Preferred Silver PPO℠ 104
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℠ 104**	
	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	None
	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	None
	Non-Participating	50% of the Eligible Charge
Hospital Emergency Care		
Emergency Accident Care from either a Participating or Non-Participating Provider	None	
Emergency Medical Care from either a Participating or Non-Participating Provider	None	
Emergency Room Deductible (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	None	
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	None
	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)*	None	
Outpatient Specialist office visits (Participating Providers)	None	
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	None	
Emergency Medical Care from either a Participating or Non-Participating Provider	None	
Other (Miscellaneous) Covered Services Blood and blood components; medical and surgical dressings, supplies, casts and splints, prosthetic devices, orthotic devices and durable medical equipment.	None	
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	$3,500*
	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	$10,500*
	Non-Participating	$45,000*
Individual Out-of-Pocket Expense Limit*	Participating	$3,500*
	Non-Participating	No limit*
Family Out-of-Pocket Expense Limit*	Participating	$10,500*
	Non-Participating	No limit*
Inpatient Hospital Deductible	Participating	None *
	Non-Participating	None*

Outpatient Surgical Deductible	Participating	None*
	Non-Participating	None*
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	
Outpatient Prescription Drug Program		
Drugs, diabetic supplies, insulin and syringes	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.

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.	Up to $150, after Deductible	Up to $30, after Deductible
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	 Covered, after Deductible Covered, after Deductible Covered, after Deductible Covered, after Deductible	 Up to $25, after Deductible Up to $35, after Deductible Up to $45, after Deductible Up to $45, after Deductible

may be an additional charge at Walmart and Sam's Club		
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 $140 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.	 Up to $150, after Deductible Up to $600, after Deductible	 Up to $75, after Deductible Up to $225, after Deductible

Note: Additional benefits over allowance are available from participating providers except 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.