

Traditional Coverage	2
Standard Insurance Card Elements	3
Participating Provider Option (PPO)—Hospital Network	5
Medical Management	7
Participating Provider Option (PPO)	13
National Accounts	16
Community Participating Option (CPO)	17
BlueEdgeSM (A Consumer Directed Healthcare Plan)	21
BlueAdvantage Entrepreneur (BAE) Health Plans	25
BlueAdvantage Entrepreneur PPO	25
BlueAdvantage Entrepreneur (BAE) BlueEdge Plan	27
BluePrint	29
BlueChoice	32
BlueChoice Select	36
Blue Cross Blue Shield of Illinois HMOs	40
BlueAdvantage HMO	46
Federal Employees Program (FEP)	47
Illinois Comprehensive Health Insurance Plan (ICHIP)	50
Medicare Supplemental	53
Medicare Select	55
Medicare Select Identification Card	57
Dental Insurance Card	58
BlueExtras Discount Program	59

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

Traditional Coverage

Basic Benefits

Basic medical/hospital benefits are a part of most insurance coverage, and varies depending on the scope of the benefits purchased. Coverage usually includes the average cost of a semi-private hospital room, general nursing services, and inpatient physician services including surgery and medical care. Inpatient ancillary services are also a part of these benefits, including operating and treatment room coverage, anesthetics, oxygen and its administration, blood and blood plasma, drugs and medicines, dressings, and medical/surgical supplies.

Major Medical (MM)

Description

This is a component of basic Blue Cross and Blue Shield coverage that pays a certain percentage of all eligible medical expenses that the member incurs during the benefit period. Those expenses not covered by basic health insurance include such services as physician office visits, allergy injections, outpatient radiation therapy, chemotherapy, prescription drugs, purchase or rental of Durable Medical Equipment (DME), private duty nursing and outpatient psychotherapy.

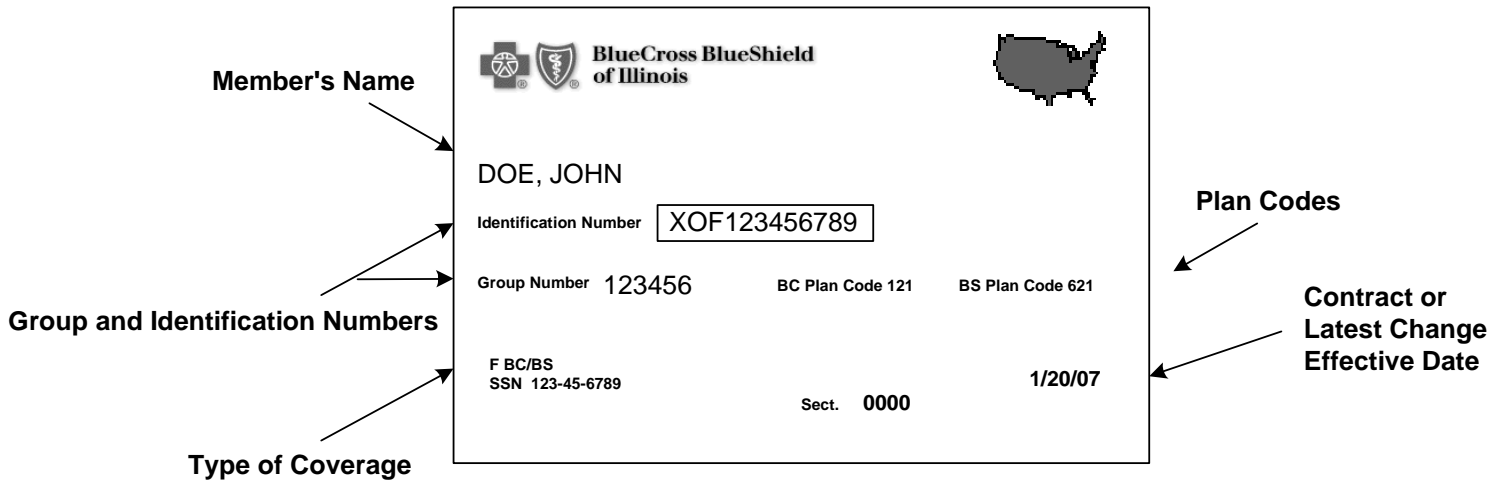
Comprehensive Major Medical (CMM)

Description

Comprehensive Major Medical is a blending of basic Blue Cross and Blue Shield and Major Medical coverage. Services that fall into either Blue Cross and Blue Shield or Major Medical coverage are paid at the same level, with one deductible amount and coinsurance level for all services in a benefit period. Specific deductibles, coinsurance levels and out-of-pocket expense limits depend on specific group contracts.

Standard Insurance Card Elements

Blue Cross and Blue Shield of Illinois (BCBSIL) offers a wide variety of health care products. Each member's card contains billing and benefit information. When filing a BCBSIL claim, two of the most important elements are the member's group and identification numbers. This is an example of a standard I.D. card. (See specific product sections in this manual for examples of other cards that identify the member's benefit plan.)



There are two types of alpha prefixes at the beginning of the identification number:

- Plan-specific
- Account-specific
- **Plan-specific alpha prefixes** are assigned to every Blue Cross and Blue Shield Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
 - First character X, Y, Z or Q
 - Second character A-Z
 - Third character A-Z

“XO” Identifies the Illinois Plan

- **Account-specific prefixes** are assigned to centrally processed national accounts, which are employer groups that have offices or branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

Standard Insurance Card Elements

The third letter identifies the product in which the member is enrolled. Each BCBS Plan has their identifying letters. The following identifies the Illinois products:

- XOP PPO (Participating Hospitals only)
- XOC PPO Plus (Participating Hospitals and Physicians)
- XOM BlueChoice
- XOY BlueChoice Select
- XOF PPO Portable
- XOH HMO (HMO Illinois and BlueAdvantage HMO)
- XOT Traditional (Comprehensive Major Medical)
- XOD Dental
- XOS Medicare Supplemental – Individual
- XON Medicare Supplemental – Group

Type of Coverage Codes

S	Single Coverage
F	Family Coverage
BC/BS	Blue Cross and Blue Shield
C/S/M	Blue Cross, Blue Shield and Supplemental Major Medical
BC	Blue Cross Only
BS	Blue Shield Only
MM	Supplemental Major Medical Only
BC/MM	Blue Cross and Supplemental Major Medical
BS/MM	Blue Shield and Supplemental Major Medical
CMM	Comprehensive Major Medical
DENTS	Dental Coverage - Single Only
DENTF	Dental Coverage – Family

The back of the identification card (see below) lists important information:

- Medical Management Precertification Telephone Number
- Mental Health/Chemical Dependency Telephone Number
- Provider Locator Telephone Number
- Claim Filing Instructions

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.

BlueCare Connection (BCC): 1-800-572-3089

Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.

FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS

Provider Locator: To find a PPO Provider in your service area or when traveling, please call: **1-800-810-BLUE (2583)** or use the provider finder at www.bcbsil.com

To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.

To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.

Customer Service: 1-800-409-9462

BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.

24/7 Nurseline: 1-800-299-0274

Pharmacy Program: 1-800-423-1973

Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

Participating Provider Option (PPO)—Hospital Network

Description

The PPO Hospital Network product is a health care benefit program designed to provide BCBSIL members with economic incentives for using designated facilities. When BCBSIL covered members use a PPO facility their benefits are paid at the highest level. Failure to use a network facility results in a reduction of benefits.

Facilities are selected for the PPO Hospital Network based on the following factors:



- PPO Hospital Network facilities have agreed to prospective and stabilized rates coupled with utilization controls. Payment is based on a single per diem rate, multiple per diem rates or on the Diagnosis Related Group (DRG).
- The PPO Hospital Network includes community, tertiary care, specialty facilities, and teaching hospitals. In order to provide a full range of health care services, the PPO Hospital Network also includes providers of ancillary services.
- The facilities are geographically located so that our members have ready access to hospitals in all areas of Illinois.

PPO Hospital Network Provider Types

- Hospitals
- Coordinated Home Care (CHC)
- Hospice
- Skilled Nursing Facility (SNF)
- Surgi-Centers
- Renal Facilities
- Free Standing Psychiatric and Chemical Dependency Facilities

PPO Hospital Network Identification Card

Many PPO Hospital Network accounts have migrated to the PPO Portable BlueCard Program. Their identification card alpha prefixes were changed to XOF. The card has a suitcase logo. For more information, please review the BlueCard Program Manual at http://www.bcbsil.com/provider/standards/bluecard_program.html.


 BlueCross BlueShield
of Illinois 

DOE, JOHN

IDENTIFICATION NUMBER XOP111223333

GROUP NUMBER P12345 BS Plan Code 621 BC Plan Code 121

Family DENTF 1/1/09

 SECT. 0004

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.

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Medical Management

Blue Cross and Blue Shield of Illinois (BCBSIL) operates the Medical Management Department to ensure our members receive the right care at the right time, right place and at the right price. Our programs are designed to promote the optimal use of health care resources to improve health care outcomes. We believe the efficient and effective use of health care service results in quality health care outcomes. We use Milliman Optimal Recovery Guidelines which are evidence and consensus based guidelines to support effective care and efficient resource utilization. BCBSIL meets the Blue Cross Association Consortium, NCQA, and URAC standards. The Medical Management Department reviews medical necessity and provides authorization for clinical services.

Pre-certification (also called preauthorization or prenotification)

Pre-certification is the process of determining medical necessity and appropriateness of the physician's plan of treatment. Most BCBSIL PPO and POS contracts require that either the member or provider notify the plan and receive prior approval from the Medical Management Department for inpatient hospital admissions, including the following services:

- Inpatient hospitalization and rehabilitation
- Skilled nursing
- Long-term acute care
- Inpatient hospice (for some groups)
- Many groups also require prenotification for Coordinated Health Care, i.e., skilled nursing visits, IV medication, etc.

Elective or non-emergency admissions must be pre-certified at least **three business days** prior to the planned admission.

Providers may pre-certify on behalf of PPO and POS members, but providers are responsible for pre-certification for the following products:

- Community Participating Option (CPO)
- Blue Advantage Entrepreneur PPO (BAE)
- Blue Print
- BlueChoice Select
- FEP (Federal Employees Program)

For **Behavioral health services (mental health and substance abuse)**, the member should contact the telephone number that is listed on the back of their identification card. See page 10 of this section for new behavioral health program preauthorization requirements, effective Jan. 1, 2011.

For HMO members, it is the responsibility of the member's physician to notify their Medical Group/Independent Practice Association (MG/IPA) for inpatient hospital admissions.

Although many groups do not require pre-certification for outpatient services there are some who do.

We encourage providers to submit eligibility and benefit requests electronically to BCBSIL via your preferred vendor portal. You may also call the BCBSIL Interactive Voice Response System (IVR) to confirm eligibility and benefits, as well as to confirm if outpatient services require pre-certification.

Facility providers may pre-certify services by accessing iEXCHANGE, an online pre-certification and case management tool. To schedule a demonstration, contact your Provider Network Consultant.

How to Navigate the IVR system for pre-certification

Refer to *Pre-certification (Prenotification or Preauthorization) Reference Guide* at www.bcbsil.com/provider/pdf/pre_certification_benefits.pdf to learn how to navigate the IVR system for pre-certification.

Appeal Information and Procedures

The Medical Management Department will notify the member/patient, physician and provider of services of a denial determination within one business day. Both verbal and written notifications are provided.

The member, member's designated representative or health care practitioner may submit written statements and other documents to be considered in the appeal process. If a health care practitioner or designated representative is submitting an appeal on the member's behalf, written or verbal authorization from the member is required unless it is an urgent care appeal.

Urgent care or expedited appeal requests are for urgent care or treatment. If the physician, the member, the member's authorized representative, facility or provider feel that the non-approval of the requested service will seriously jeopardize the health of the member, and the services are imminent or ongoing, the physician or the facility may request an expedited appeal by calling the number listed on the back of the member's identification card or (888) 978-9034.

If it is not an urgent care request, a **standard appeal** may be requested in writing or by phone within 180 days of receipt of the denial notice. Please include the following information:

- Member name, identification number and group number
- Dates and place of service
- Reference or claim number
- Types of service/procedure received
- Any supporting documentation, including medical records or other information to be considered with the appeal.

Please utilize the "Appeal Request" form for appeal submission. This form will be attached to the denial letter. This form will allow the Appeals Department to process the appeal request promptly and efficiently. Please submit requests to the Appeal Department at:

Attention: Appeal Coordinator
Blue Cross and Blue Shield of Illinois
Medical Management Appeals Department
300 E. Randolph Street
Chicago, Illinois 60601-5099

Behavioral Health (Mental Health and Substance Abuse)

Care Management Program

The BCBSIL Behavioral Health Program encompasses a portfolio of resources that help BCBSIL members access benefits for behavioral health (mental health and substance abuse) conditions as part of an overall care management program. BCBSIL has integrated behavioral health care management with our member Blue Care Connection (BCC) medical care management program to provide better care management services across the health care continuum. It also allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions. Our licensed behavioral health clinicians use the Milliman Behavioral Health Guidelines or BCBSIL Medical Policies as clinical screening criteria.

BCBSIL manages behavioral health care services for the following products:

- **PPO**
- **BlueChoice Select[®]**

Exception: Some employer groups are managed by other behavioral health vendors.

BCBSIL does not manage behavioral health services for:

- **HMO Illinois[®] and BlueAdvantage[®] HMO**
 - BCBSIL has delegated mental health services for HMO Illinois and BlueAdvantage HMO members to the member's MG/IPA.
 - Magellan Health Services administers Substance Abuse services for HMO Illinois and BlueAdvantage HMO members.
- **The Employee Assistance Program (EAP)**

Magellan Health Services administers the Employee Assistance Program (EAP) for all members who have BCBSIL EAP benefits.

Preauthorization Requirements for Behavioral Health Services

Preauthorization is the process of determining medical appropriateness of the behavioral health professional's or physician's plan of treatment by contacting BCBSIL or the appropriate behavioral health vendor for approval of services.

Approval of services after preauthorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any preexisting conditions waiting period, if any.

Services That Require Preauthorization

Inpatient

- Elective, non-emergency or partial hospital admissions must be preauthorized at least one day prior to admission or within two business days of an emergency admission.

Note: In emergencies, the physician or other professional provider must first ensure that the member is safe. Preauthorization will then occur prior to or concurrent with, but not more than two business days following the admission. A life-threatening emergency or crisis is a condition that requires immediate interaction to prevent death or serious harm to the member or others. It is characterized by sudden onset, rapid deterioration of cognition, judgment, behavior, and is time limited in intensity and duration.

- Although BCBSIL generally excludes admission into a Residential Treatment Center (RTC), there are some employer groups that have elected to cover this service. To determine eligibility and benefit coverage prior to service and determine if RTC is covered, members or behavioral health professionals and physicians may call the Behavioral Health number that is listed on the back of the member's ID card.

Outpatient

The five covered behavioral health services listed below require preauthorization before initiation of service:

- To preauthorize these services, call the number on the back of the member's ID card, or (800) 851-7498.
 1. Outpatient electroconvulsive therapy (ECT)
 2. Intensive outpatient programs (IOP)
 3. Partial hospital admissions (PHP) - Non-emergency care must be preauthorized at least one day prior to admission or within two business days of an emergency admission.
 4. Psychological testing*
 5. Neuropsychological testing*

*For these services, preauthorization requires completion of a [Testing Request form](#).

Note: This does not apply to Federal Employee Program (FEP) members. For FEP members, prior authorization is not required before receiving outpatient professional or outpatient facility care for behavioral health services.

The Process and Associated Steps to Preauthorization:

Behavioral health professionals and physicians should always verify eligibility and benefits prior to providing services:

- **Online:**
Electronically submit a HIPAA 270 transaction (eligibility) to BCBSIL through your preferred vendor portal, or
- **Telephone:**
Call the number that is listed on the back of the member's ID card.

Inpatient

- Members are responsible for requesting preauthorization for inpatient services. Behavioral health professionals and physicians may request preauthorization on behalf of the member.
- Call the appropriate number on the back of the member's ID card.
- All services must be medically necessary.

Failure to preauthorize:

- Members who do not request preauthorization for inpatient behavioral health treatment may experience the same benefit reductions that apply for inpatient medical services.
- Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

Outpatient

- When outpatient preauthorization is required, members should call the Pre-auth MH/SA number listed on the back of their ID card. Behavioral health professionals and physicians, or the member's family, acting on behalf of the member, may also place the preauthorization call. This number directs the preauthorization call to either BCBSIL or to the appropriate behavioral health vendor.

Failure to preauthorize:

- If a member receives outpatient behavioral health services that require preauthorization without requesting preauthorization, the behavioral health professional or physician will be asked to submit clinical information for a medical necessity review. The member will also receive notification.
- Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

All behavioral health professionals and physicians, both BCBSIL network and out-of-network, must submit clinical information/forms as requested to:

<p>Fax: (877) 361-7656</p>	<p>Mail: Blue Cross and Blue Shield of Illinois Behavioral Health Unit P.O. Box 660240 Dallas, TX 75266-0240</p>
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Resources

Additional information on our Behavioral Health Care Management Program can be found on our website at www.bcbsil.com/provider, in the Clinical Resources section. There you can view [Clinical Practice Guidelines](#) for common behavioral health conditions and [Medical Necessity criteria](#).

Condition Management Program

BCBSIL has designed programs to assist members with knowledge and treatment of their clinical condition. Our goal is to enhance the physician patient relationship by providing members with information to take charge of their health status and understand the treatment plan from their physician. While these programs change from time to time and are not included in all benefit plans, please feel free to contact the Condition Management Department if you believe we can assist you with a member dealing with a chronic condition. The Condition Management Department can be reached at (866) 308-4778.

The Disease Management Programs currently available for **PPO members** include:

- Asthma
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Diabetes

For members in **an HMO**, programs available include:

- Cardiovascular Disease
- Asthma
- Diabetes
- Hypertension

Providers caring for **HMO members** may call the Quality Improvement (QI) Department at (312) 653-3465 for more information about the Disease Management Programs.

Predetermination of Benefits

A predetermination of benefits is a written request for verification of benefits prior to services being rendered. A predetermination is recommended when the services could be considered experimental, investigational or cosmetic.

Predetermination approvals and denials are based on provisions in our medical policies. Medical policies located on our website at www.bcbsil.com/provider may also be used as a guideline to determine what documentation is required with the request. Click on Medical Policy located in Standards and Requirements.

Requests are made using the Predetermination Request Fax Form located in the Provider website at www.bcbsil.com/provider. Click on Education and Reference Center and select Forms. Complete and fax all requests to (800) 852-1360.

Providers must also verify eligibility and benefits because a predetermination approval does not guarantee payment for services, since benefits are also subject to eligibility and coverage limitations at the time services are rendered.

Predetermination for High Tech Imaging Services

BCBSIL contracted with American Imaging Management, Inc. (AIM) to implement a radiology quality program. Ordering physicians must obtain RQI numbers from AIM for High Tech Imaging Services. The RQI is required for:

- CT scans
- CTA scans
- MRI, MRS, MRA scans
- Nuclear cardiology studies
- PET scans

The RQI is valid for 30 days. There is no grace period if the service is not performed.

The ordering physician must prospectively obtain the RQI number. The performing imaging providers cannot obtain a RQI number but should verify that a RQI number was issued prior to performing the service. (Hospitals have access to the AIM website to verify the RQI by entering the member name and identification.)

To obtain an RQI the physician may access the AIM website at www.americanimaging.net or call the AIM Call Center at (800) 455-8415.

The RQI is required when the place of service is:

- Freestanding imaging center
- Hospital outpatient
- In office use of physician owned equipment

The RQI is not required when the place of service is:

- Hospital inpatient
- Emergency room
- Urgent care center
- 23 hour observation

The physician must obtain an RQI for the following products:

- BlueChoice Select
- Illinois PPO
- Blue Advantage Entrepreneur PPO
- FEP
- Labor Groups

HMO Illinois and Blue Advantage Entrepreneur HMO do not require an RQI number.

In addition to Illinois, some BCBS Plans do have radiology management programs and some of these programs are tied to member benefits, therefore it is important to check benefits prior to service. This information will be given when you verify eligibility and benefits for out-of-area members at (800) 676-BLUE (2583).

For Illinois members, eligibility and benefits may be verified by submitting a HIPAA 270 transaction (eligibility) to BCBSIL through your preferred vendor portal or by calling the BCBSIL IVR at (800) 972-8088.

Participating Provider Option (PPO)

Description

The PPO product is a health care benefit program that is made up of PPO facilities and professional providers (see list below). When BCBSIL members use the PPO network of providers and hospitals, they receive comprehensive benefits and reduce the amount they have to pay for medical services. When members choose to use non-participating providers and hospitals, their benefits are substantially reduced.

All participating providers have contractually agreed to utilization management to ensure cost savings. Utilization management is performed through the Medical Management Department, which is a standard component of the PPO product. The Medical Management Department functions to ensure quality medical care and cost savings

Professional Provider Network

Providers must have a valid state license in Illinois, or in the state in which they render service to BCBSIL members, have signed the Mutual Participation Program (MPP) contract and the PPO Plus Addendum contract. To confirm PPO participation in the PPO network, use the Provider Finder[®] on our website at www.bcbsil.com.

The PPO network eligible providers are:

- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Surgical Assistants (CSAs)
- Certified Surgical Technologists (CSTs)
- Chiropractors
- Clinical Psychologist
- Durable Medical Equipment
- Home Infusion
- Independent Lab
- Licensed Clinical Nurse Specialist
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist
- Optometrists
- Orthotics
- Osteopaths
- Physicians
- Podiatrists
- Prosthetics
- Registered Nurse First Assistants (RNFAs)
- Registered Surgical Assistants (RSAs)
- Sleep Medicine
- Surgical Assistants Certified (SACs)
- Therapist (Physical, Speech, Occupational)

Facility Provider Network

PPO contracted facilities consist of the following network provider types:

- Hospitals
- Coordinated Home Care (CHC)
- Hospice
- Skilled Nursing Facility (SNF)
- Surgi-Centers
- Renal Facilities
- Free Standing Psychiatric and Substance Abuse Centers

Precertification Requirements

Most PPO contracts require plan notification and Medical Management approval for inpatient hospital admissions. Some contracts require notification and approval for specified outpatient procedures. Additionally, care for mental health and substance abuse generally requires notification and authorization. Specific time frames for notification vary according to employer requirements. This information along with notification phone numbers is listed on the back of the member's identification card, or for facility providers you may access iEXCHANGE, an online pre-notification and case management tool. All providers may call the Interactive Voice Response (IVR) system at (800) 972-8088 for pre-certification

Referrals

When a referral for a covered member is necessary, the provider must make every effort to refer the member to in-network PPO professional providers and facility providers, hospitals, and ancillary facilities that are required by some contracts. Providers must remember that referrals to out-of-network providers could result in reduced benefits for the member. To confirm PPO participation, use the Provider Finder[®] tool on our website at www.bcbsil.com.

Benefits

- **In-network benefits:** Members must use participating providers to receive comprehensive benefits.
- **Out-of-network benefits:** Members may use non-participating providers, but this will result in a reduction of benefits.

Specific benefits vary according to individual or employee contracts. Providers should access NDAS Online for specific member benefits or call the Interactive Voice Response (IVR) at (800) 972-8088.





Copayments

Some PPO contracts do have copayments for office visits, emergency room visits, and outpatient services. Copayments should be listed on the member's ID card; however, some employer groups choose not to show the copayment amount on the ID card. **The copayment amount can always be determined by using NDAS Online or calling the Interactive Voice Response (IVR) at (800) 972-8088.**

PPO Identification Card

Many PPO accounts have migrated to the PPO Portable BlueCard Program. These identification card alpha prefixes were changed to XOF. The card has a suitcase logo. For more information, please review the BlueCard Program Manual at http://www.bcbsil.com/provider/bluecard_program.htm. You may still see some PPO ID cards with the alpha prefix XOC.

Medical Management may be contacted at the phone number that is specified on the back of the member's ID card.

 	<p>To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions. Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program. BlueCare Connection (BCC): 1-800-572-3089 Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission. FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS Provider Locator: To find a PPO Provider in your service area or when traveling, please call: 1-800-810-BLUE (2583) or use the provider finder at www.bcbsil.com To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan. To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance. Customer Service: 1-800-409-9462 BlueAccess for Members at: www.bcbsil.com for claims and eligibility information. 24/7 Nurseline: 1-800-299-0274 Pharmacy Program: 1-800-423-1973 <small>Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims</small></p>
<p>DOE, JOHN</p> <p>Identification No. XOF112223333</p> <p>Group No. P12345 BS Plan Code 621 BC Plan Code 121</p> <p> PRIME BIN:011552  PCN: ILDR</p>	





National Accounts

National accounts are those employer groups that have offices or branches in more than one area, but offer uniform coverage benefits to all of their employees.

Guidelines for national accounts:

- Membership crosses state lines
- Claims are processed by the local Plan
- Provider inquiries are handled by the local Plan in most cases

National account ID cards do not have a Plan-specific alpha prefix that identifies the Plan from where the account originates. Typically, a national account alpha prefix will relate to the name of the group. These claims should be submitted to BCBSIL.

	BlueCross BlueShield An Independent Licensee of the Blue Cross and Blue Shield Association		UNITED AIRLINES Traditional Medical Plan
Doe, Jane			
Identification Number	UAL111223333		
Group No.	081204		
Family			
PRE-CERTIFY ALL INPATIENT CARE IN U.S.			

<p>For benefits questions or to pre-certify U.S. inpatient care, call BlueCross BlueShield Customer Service: 1-800-5-FLY-UAL (1-800-535-9825) Claims Processing</p>
<p>To the Provider: File claims in the usual manner to your local BlueCross BlueShield Plan. To the Member: If the provider does not submit the claim on your behalf, send your claims to Blue Cross Blue Shield of Illinois, P.O. Box 1220, Chicago, Illinois 60690.</p>
<p>CAREWISE/BABYWISE: 1-800-219-2181 (24 Hour service) TO REQUEST A PERSONALIZED DIRECTORY: 1-800-821-1188 UAL BENEFITS SERVICE CENTER: 1-800-482-5236 CAREMARK: 1-888-433-0075</p>
<p style="text-align: center;">Caremark Prescription Drug Instructions</p> <p>Present this card to any participating pharmacy in the U.S. and Puerto Rico to obtain a discount on your medication.</p> <p style="text-align: center;">To the Pharmacist:</p> <ul style="list-style-type: none"> • Input CRK in the Plan Code Field • Input UAL in the Group Code Field • Input employee's file number (Social Security number for COBRA members) • 100% co-payment for generic and brand name medications. • Unlimited days supply per prescription.

Community Participating Option (CPO)

Description

The Community Participating Option (CPO) is a subset of the larger PPO network, and encourages members to receive health care from local participating CPO community providers. When members use their CPO network of providers and hospitals, they receive the highest level of benefits. If members choose to select hospitals and physicians that are part of the standard PPO network, they will still receive a high level of coverage. Members who choose to use non-participating providers will receive a lower level of insurance and assume the largest responsibility for the cost of their care.

Physician Network

Participating CPO physicians are identified through the participating CPO hospital for each region. The preferred CPO physician is required to have admitting privileges with the local CPO hospital. In addition, CPO physicians must sign the MPP contract and the PPO Plus Addendum contract.

Hospital Network

The CPO participating hospital must be PPO contracted. Each CPO community health plan is required to have at least one CPO hospital.

CPO Plans

Each member participates through their employer with one of the following CPO plans:

CPO Plan Number	Plan Name
CO1	Starved Rock Community Health Plan ▪ Illinois Valley Community Hospital and Physician Hospital Organization – Peru
CO2	Grundy Advantage Community Health Plan ▪ Morris Hospital – Morris
CO3	Galesburg Regional Health Plan ▪ Galesburg Clinic and St. Mary's Medical Center – Galesburg
CO4	Community Health Plan of Southeast Illinois ▪ Richland Memorial Hospital – Olney ▪ Lawrence County Memorial Hospital – Lawrenceville ▪ Clay County Hospital – Flora
CO5	Hometown Health Plan ▪ Community Hospital of Ottawa – Ottawa
CO6	The Prairie Cities Health Plan ▪ Kewanee Hospital – Kewanee

CPO Plan Number	Plan Name
CO7	Macoupin Central Communities Health Plan ▪ Carlinville Area Hospital – Carlinville
CO8	Sparta Regional Health Plan ▪ Sparta Community Hospital – Sparta
CO9	Bureau Valley Community Health Plan ▪ Perry Memorial Hospital – Princeton
CO10	Community Advantage Health Plan ▪ St. Vincent Memorial Hospital – Taylorville
CO11	Riverbend Regional Health Plan ▪ Trinity Regional Health Systems - Rock Island, Moline ▪ Hammond-Henry Hospital – Geneseo
CO12	Litchfield-Gillespie Regional Health Plan ▪ St. Francis Hospital – Litchfield
CO13	Community Advantage Regional Health Plan ▪ Iroquois Memorial Hospital – Watseka
CO14	Peoria Area Community Network ▪ St. Francis Medical Center/OSF – Peoria
CO15	Staunton Community Health Plan ▪ Community Memorial Hospital – Staunton
CO16	Hometown Advantage Community Health Plan ▪ Jersey Community Hospital – Jerseyville ▪ Boyd Memorial Hospital – Carrollton
CO17	The Community Advantage Health Plan ▪ Abraham Lincoln Memorial Hospital – Lincoln
CO18	The Community Advantage Health Plan ▪ Passavant Area Hospital – Jacksonville
CO19	The Community Advantage Health Plan ▪ Greenville Regional Hospital – Greenville
CO20	Hometown Advantage Health Plan ▪ OSF Saint James Hospital – Pontiac
CO21	Perry County Regional Health Plan ▪ Pinckneyville Community Hospital – Pinckneyville
CO22	Southern Illinois Community Blue ▪ Southern Illinois Healthcare
CO23	Fairfield Community Advantage ▪ Fairfield Memorial Hospital – Fairfield
CO24	Central Illinois Regional Health Plan ▪ Decatur Memorial Hospital
CO25	The Sauk Valley Health Plan ▪ CGH Medical Center – Sterling
CO26	KVH Blue ▪ Riverside Healthcare – Kankakee ▪ Kankakee Valley Healthcare – Kankakee
CO27	East Central Community Advantage ▪ Christie Clinic and Provena Covenant Medical Center – Champaign/Urbana
CO28	McLean-Woodford Regional Health Plan ▪ BroMenn Regional Medical Center – Bloomington/Normal




Copayments

- Option 1 \$10 office visit copayment is required at the time of service.
- Option 2 \$20 office visit copayment is required at the time of service.

Deductibles

CPO plans have a differential in the deductible, out-of-pocket expenses and coinsurance that result in optimal benefits when members use CPO providers.

CPO Identification Card

	<p>BlueCross BlueShield of Illinois</p> <p>An Independent Licensee of the Blue Cross and Blue Shield Association</p>	<p>Community Participating Option</p>
<p>Doe, John D.</p>		
<p>Identification No.</p>	<p>XOF111223333</p>	
<p>Group No. P80026</p> <p>Family</p>	<p>BS Plan Code 621 BC Plan Code 121</p>	<p>01-01-09</p>
	<p>C01 Starved Rock CHP</p>	<p>PRIME BN011552 PCN ILDR </p>

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program. **BlueCare Connection (BCC): 1-800-572-3089**

Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.
FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS

Provider Locator: To find a PPO Provider in your service area or when traveling, please call: **1-800-810-BLUE (2583)** or use the provider finder at www.bcbsil.com
To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.
To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.

Customer Service: 1-800-409-9462

BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.
24/7 Nurseline: 1-800-299-0274
Pharmacy Program: 1-800-423-1973

Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

BlueEdgeSM (A Consumer Directed Healthcare Plan)

Description

BlueEdge, is a Consumer Driven Healthcare Plan offered to BCBSIL members. It is a PPO Plan that typically combines a high deductible with a spending account that can be used for eligible medical expenses. BlueEdge provides internet tools to members, empowers smart health care choice and promotes healthy behaviors by encouraging members to take an active role in managing their health care.

Spending Accounts

BlueEdge offers two types of spending accounts: Health Care Account (HCA) and Health Spending Account (HSA). Both spending accounts can be used for eligible medical expenses and deductibles.

	Health Care Account (HCA)	Health Spending Account (HSA)
Who funds the account?	Employer, who owns the account. The employer determines the amount of the remaining funds that rollover to be added to the next yearly HCA. Funds are not portable if the employee leaves the company.	Employer and/or employee fund the account; the member owns the account. Remaining funds rollover to be added to the next yearly HSA. Funds are portable if the member leaves the company.
When the account is depleted who pays remaining deductible?	Employee	Employee
How are eligible health care benefits paid?	Automatically from the HCA	Automatically from the HSA if the HSA is with ACS/Mellon AND the auto claims feature has been elected. For members without ACS/Mellon auto claims feature or with HSA Bank or other non-integrated banks, members will have debit cards and bank checkbooks administered through a bank. While employers may offer a bank option to employees, the final selection of a bank custodian is up to the individual employee, as HSAs are individually owned bank accounts.
When do BlueEdge PPO Plan benefits begin?	When deductible is met	When deductible is met.
Are there online tools?	Yes, at www.bcbsil.com .	Yes, at www.bcbsil.com including links to the bank websites for integrated banking partners such as ACS/Mellon and HSA Bank.

Provider Network

The BlueEdge network is the same as the standard BCBSIL PPO network. Providers who have a PPO contract with BCBSIL do not need to re-contract for BlueEdge. Eligible providers include:

PPO Hospital Network	PPO Professional Network
Hospitals Coordinated Home Care (CHC) Hospice Skilled Nursing Facility (SNF) Surgi-Centers Renal Facilities Free standing psychiatric and Substance Abuse Facilities	Certified Nurse Midwives Certified Nurse Practitioners Certified Registered Nurse Anesthetist (CRNA) Certified Surgical Assistants (CSAs) Certified Surgical Technologists (CSTs) Chiropractors Clinical Psychologist Durable Medical Equipment Home Infusion Independent Lab Licensed Clinical Nurse Specialist Licensed Clinical Professional Counselors (LCPC) Licensed Clinical Social Worker (LCSW) Licensed Marriage and Family Therapist Optometrists Orthotics Osteopaths Physicians Podiatrists Prosthetics Registered Nurse First Assistants (RNFAs) Registered Surgical Assistants (RSAs) Sleep Medicine Surgical Assistants Certified (SACs) Therapist (Physical, Speech, Occupational)

Additionally, national and international PPO providers are available to PPO members through the BlueCard Program.

Locating PPO Network Providers

- **Local and National**
PPO network providers can easily be located at www.bcbsil.com by selecting Provider Finder[®] or calling BlueCard Access at (800) 810-BLUE (2583).
- **International**
PPO providers can be located by calling BlueCard Access at (800) 810-BLUE (2583).

Benefits

BlueEdge benefits, which are the same as standard PPO benefits, become effective when the HCA/HSA funds are spent and deductibles met.

- **In-network benefits:** Members must use participating providers to receive comprehensive benefits
- **Out-of-network benefits:** Members may use non-participating providers, but this will result in a reduction of benefits.

Specific benefits and coinsurance amounts may vary for each employer group. To determine eligibility and specific benefits you may access NDAS Online. If you do not have access to NDAS Online and are interested, you may find information to sign up for this free service at www.bcbsil.com/provider. You may also call the Interactive Voice Response (IVR) at (800) 972-8088 for eligibility and benefits.

Preventive Wellness and Routine Care

Preventive wellness and routine care are covered at 100% in-network even before the deductible is met. Preventive wellness includes:

- Physicals and routine check-ups
- Diagnostic tests
 - Routine lab
 - Routine x-rays
 - Mammograms
- Well child care and immunizations

Referrals

When a referral for a covered member is necessary, the provider must make every effort to refer the member to in-network PPO providers. Providers must remember that referrals to out-of-network providers could result in reduced benefits for the member. Providers and members may log on to www.bcbsil.com for the Provider Finder[®] to search for a PPO provider.

Precertification Requirements

Like most PPO contracts plan notification and Medical Management approval for inpatient hospital admissions is required. Some employer accounts require notification and approval for specified outpatient procedures as well. Additionally care for mental health and chemical dependency generally requires notification and authorization. Specific time frames for notification vary according to employer requirements. This information, along with notification phone numbers, is listed on the back of the member's identification card. You may also access the NDAS Online database or call the Interactive Voice Response (IVR) at (800) 972-8088. If you do not have access to NDAS Online and are interested in learning more, you may find information sign up for this free service at www.bcbsil.com/provider.

Copayments

There are no co-payments for the BlueEdge plan.

Billing

Claims are submitted to BCBSIL in the CMS-1500 or UB-04 format.

Services are reimbursed directly to PPO providers:

- Professional providers are paid according to the PPO Schedule of Maximum Allowances (SMAs).
- Facility providers are paid their PPO contractual allowance.
- Subsequent to receipt of the Provider Claim Summary (PCS), the patient may be billed for any remaining deductible and coinsurance amount.

Reimbursement, Deductible and Coinsurance

BlueEdge claims are paid by BCBSIL from the HCA/HSA until the amount is used up. The amount paid from the HCA/HSA goes toward meeting the deductible. The member becomes responsible for the deductible, as well as the coinsurance, when the HCA/HSA funds are spent. BlueEdge Plan benefits begin when the Plan deductible is met. HSA and HCA funds may be used for qualified medical expenses such as those listed in IRS Publication 502, section 213(d). Any amount not spent from the HCA/HSA rolls over to be added to the next yearly HCA/HSA amount. But with the HCA account, the employer determines how much of the HCA account is rolled over.






There is no deductible for preventive/wellness visits. These services are paid at 100% even before the deductible is met.

Online Tools Available to Members

BlueAccess for Members is a BCBSIL online service that enables members to review the status of their HCA/HSA including current balance and payments made to date. Members can check the status of a claim, view the EOB and confirm who is covered under their plan. They are given the option to receive e-mail notification when a claim for a member or dependent has been finalized by BCBSIL.

Extensive health and wellness information is available online through a contractual arrangement with Mayo Clinic. The expertise and resource of Mayo Clinic allows BCBSIL to bring members practical and useful health information – whether they want to improve their overall health, manage a chronic health condition or prepare for a specific medical treatment. Mayo Clinic has even created custom health materials just for BCBSIL members. All information is available through BlueAccess for Members.

BlueEdge PPO Identification Card

 	<p>To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions. Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program. BlueCare Connection (BCC): 1-800-572-3089 Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission. FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS Provider Locator: To find a PPO Provider in your service area or when traveling, please call: 1-800-810-BLUE (2583) or use the provider finder at www.bcbsil.com To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan. To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance. Customer Service: 1-800-409-9462 BlueAccess for Members at: www.bcbsil.com for claims and eligibility information. 24/7 Nurseline: 1-800-299-0274 Pharmacy Program: 1-800-423-1973 <small>Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.</small></p>
<p>DOE, JOHN</p> <p>Identification No. XOF112223333</p> <p>Group No. 212345 BS Plan Code 621 BC Plan Code 121</p> <p>  </p>	

Note: The BlueEdge Identification card is the same as the Standard PPO card.

BlueAdvantage Entrepreneur (BAE) Health Plans

BlueAdvantage Entrepreneur (BAE) Health Plan is a managed care triple option product, which consists of the BAE PPO, BAE HMO, and BAE Blue Edge HSA plans typically offered to groups of 2-50 employees that are located in the Chicago metropolitan and state market areas. Employees may choose from a number of benefit designs to select the copayment, deductibles, out-of-pocket limits, and benefit package that best fit their budgets.

BlueAdvantage Entrepreneur PPO

Description

The BlueAdvantage Entrepreneur (BAE) PPO program is made up of physicians and hospitals that participate in the standard BCBSIL PPO program. There is a cost savings when the member receives care through PPO network providers. Employees can choose any physician or hospital; however, comprehensive benefits are paid when in-network providers are used. Conversely there is a reduction of benefits when out-of-network providers are used.

Provider Network

Providers who are members of the regular BCBSIL PPO network automatically qualify for the BlueAdvantage Entrepreneur PPO network of providers. Providers are responsible for notifying BCBSIL of any changes in their location, or of any new physicians within their medical group. To confirm PPO participation in the PPO network, use the Provider Finder[®] on our website at www.bcbsil.com.

Precertification Requirements

PPO providers are responsible for contacting the Medical Management Department for **inpatient hospitalization, inpatient emergency and inpatient maternity**.

If the provider fails to call, the member is held harmless and the provider may not bill the member for any reduction in payment.

The member is responsible for pre-certification **if they use out-of-network or out-of-state providers**.

Referrals

When a referral for a BlueAdvantage Entrepreneur (BAE) PPO covered person is necessary, the provider must use every effort to refer the member to in-network PPO providers and in-network PPO hospitals. Providers must remember that referrals to out-of-network providers could result in reduced benefits for the member. To confirm PPO participation use the Provider Finder[®] on our website at www.bcbsil.com.

Benefits

- **In-network benefits:** Members must use PPO providers to receive comprehensive benefits.
- **Out-of-network benefits:** Members may use non-participating providers, but this will result in a reduction in benefits.



Specific BlueAdvantage Entrepreneur (BAE) PPO benefits vary depending on which plan the member has chosen. Providers should access NDAS Online for specific member benefits, or call the Interactive Voice Response (IVR) at (800) 972-8088.

Copayments

- BlueAdvantage Entrepreneur (BAE) PPO does have a copayment for office visits, based on the member’s plan design.
- Copayments are not listed on the member’s card; however they can be determined by using NDAS Online or by calling the Interactive Voice Response (IVR) at (800) 972-8088.

BlueAdvantage Entrepreneur Health Plans Identification Cards

BlueAdvantage Entrepreneur Health Plan ID cards have either the letter **H (HMO)** or **F (PPO BlueCard)** in the third position of the alpha prefix.

 BlueCross BlueShield of Illinois		BlueAdvantage PPO	
DOE, JOHN			
IDENTIFICATION NO.	P00000-XOF123456789		
GROUP NO. P00000	BS Plan Code 621	BC Plan Code 121	
Family	Sect. 0000	01-01-09	
	PRIME BIN:011552 PCN:ILDR	Rx	

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.

Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.

BlueCare Connection (BCC): 1-800-572-3089

Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.

FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS

Provider Locator: To find a PPO Provider in your service area or when traveling, please call: **1-800-810-BLUE (2583)** or use the provider finder at www.bcbsil.com

To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.

To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.

Customer Service: 1-800-409-9462

BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.
24/7 Nurseline: 1-800-299-0274
Pharmacy Program: 1-800-423-1973

Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

BlueAdvantage Entrepreneur (BAE) BlueEdge Plan

Description

Blue Advantage Entrepreneur Blue Edge is a low cost PPO Plan, which is designed to be compatible with Health Savings Accounts.(HSA) Members may use any hospital or physician of choice, but will receive a reduction of benefits if they use out-of-network providers.

Provider Network

Providers who are members of the regular BCBSIL PPO network automatically qualify for the BlueAdvantage Entrepreneur PPO network of providers. Providers are responsible for notifying BCBSIL of any changes in their location, or of any new physicians within their medical group. To confirm PPO participation in the PPO network use the Provider Finder[®] on our website at www.bcbsil.com.

Precertification Requirements

PPO providers are responsible for contacting the Medical Management Department for **inpatient hospitalization, inpatient emergency and inpatient maternity**.

If the provider fails to call, the member is held harmless and the provider may not bill the member for any reduction in payment.

The member is responsible for pre-certification **if they use out-of-network or out-of-state providers**.

Referrals

When a referral for a BAE Blue Edge covered person is necessary, the provider must make every effort to refer the member to in-network PPO providers and in-network PPO hospitals. Providers must remember that referrals to out-of-network providers could result in reduced benefits for the member. To confirm PPO participation in the PPO network, use the Provider Finder[®] on our website at www.bcbsil.com.

Benefits




- **In-network benefits:** Members must use PPO providers to receive comprehensive benefits.
- **Out-of-network benefits:** Members may use non-PPO providers, but this will result in a reduction of benefits.

Specific benefits vary depending on which option the member has chosen. Providers should access NDAS Online for specific member benefits, or call the Interactive Voice Response (IVR) at (800) 972-8088.

Copayments

- BlueAdvantage Entrepreneur (BAE) BlueEdge Plan does have a copayment for office visits, based on the member's plan design.
- Copayments are not listed on the member's card; however they can be determined by using NDAS Online or by calling the Interactive Voice Response (IVR) at (800) 972-8088.

BlueAdvantage Entrepreneur Blue Edge members have the same ID cards as BlueAdvantage Entrepreneur PPO members.

 <p>BlueCross BlueShield of Illinois</p> <p>BlueAdvantage PPO Alternative Plan</p> <p>DOE, JOHN</p> <p>Identification No. XOF123456789</p> <p>Group No. P00000 BS Plan Code 621 BC Plan Code 121</p> <p>Family DENTF</p> <p> PRIME BIN011562 PCN: ILDR </p>	<p>To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions. Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.</p> <p style="text-align: center;">BlueCare Connection (BCC): 1-800-572-3089</p> <p>Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission. FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS</p> <p>Provider Locator: To find a PPO Provider in your service area or when traveling, please call: 1-800-810-BLUE (2593) or use the provider finder at www.bcbsil.com To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan. To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.</p> <p>Customer Service: 1-800-409-9462</p> <p>BlueAccess for Members at: www.bcbsil.com for claims and eligibility information. 24/7 Nurseline: 1-800-299-0274 Pharmacy Program: 1-800-423-1973</p> <p><small>Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.</small></p>
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BluePrint

BluePrint is a BCBSIL product tailored for employer groups with 51 to 150+ employees. It offers employers the opportunity to build a health plan of their choice by offering a PPO design as the foundation and then adding an optional HMO Plan. BluePrint offers a choice of HMO networks: the regular HMO Illinois network or the BlueAdvantage HMO network. The BluePrint Plan is also designed to be compatible with a BluePrint Health Care Savings Account (HSA)

BluePrint PPO Description

The BluePrint product is a health benefit plan that is tailored for employer groups with 51 to 150 plus employees. It offers a wide range of comprehensive benefit designs, including options for coinsurance, deductibles and out-of-pocket maximums, as well as office visit and drug card copayments.

Provider Network

BluePrint PPO utilizes the standard PPO network. Additionally BluePrint members participate in the BlueCard PPO Program.

Professional Provider Network

Providers must have a valid state license in Illinois, or in the state in which they render service to BCBSIL members, have signed the MPP contract and the PPO Plus Addendum contract. To confirm PPO participation in the PPO network use the Provider Finder[®] on our website at www.bcbsil.com. The PPO network eligible providers are:

- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Surgical Assistants (CSAs)
- Certified Surgical Technologists (CSTs)
- Chiropractors
- Clinical Psychologist
- Durable Medical Equipment
- Home Infusion
- Independent Lab
- Licensed Clinical Nurse Specialist
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist
- Optometrists
- Orthotics
- Osteopaths
- Physicians
- Podiatrists
- Prosthetics
- Registered Nurse First Assistants (RNFAs)
- Registered Surgical Assistants (RSAs)
- Sleep Medicine
- Surgical Assistants Certified (SACs)
- Therapist (Physical, Speech, Occupational)

Facility Provider Network

PPO contracted facilities include the following network provider types:

- Hospitals
- Coordinated Home Care (CHC)
- Hospice
- Skilled Nursing Facility (SNF)
- Surgi-Centers
- Renal Facilities
- Free Standing Psychiatric and Chemical Dependency Facilities

Precertification Requirements

The BluePrint product includes a provider driven pre-certification requirement for inpatient hospital services. When the BluePrint member uses an in-network BCBSIL hospital, the hospital – not the member – is responsible for contacting the Medical Management Department. If the member uses an out-of-network hospital or an out of state hospital, the member must call the Medical Management Department to receive the highest level of benefits.

Referrals

When a referral for a covered member is necessary, the provider must make every effort to refer the member to in-network PPO professional providers, PPO facilities, hospitals, and ancillary providers that are required by some contracts. Providers must remember that referrals to out-of-network providers could result in reduced benefits for the member. To confirm PPO participation use the Provider Finder[®] on our website at www.bcbsil.com. Members can use Provider Finder to locate an in-network physician or hospital.

Benefits

- **In-network benefits:** Members must use participating providers to receive comprehensive benefits.
- **Out-of-network benefits:** Members may use non-participating providers, but this will result in a reduction of benefits.

Specific benefits vary according to individual or employee contracts. Providers should access NDAS Online functions for specific member benefits or call the Interactive Voice Response (IVR) at (800) 972-8088.



Copayment

The BluePrint PPO health benefit plan offers different options for copayments. The copayment will be listed on the health insurance identification card.

Deductible and Coinsurance

BluePrint offers a wide range of deductible and coinsurance options that providers can obtain by accessing NDAS Online or call the IVR at (800) 972-8088.

BluePrint PPO Health Insurance Identification Card

 BlueCross BlueShield of Illinois 


DOE, JOHN

Identification No. XOF123456789

Copays:
Office Visit \$10
Emergency \$50

GROUP NUMBER P12345 BS Plan Code 621 BC Plan Code 121

Single DENTIF

 PRIME
BIN011552 Rx
PCN: ILDR

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.

BlueCare Connection (BCC): 1-800-572-3089

Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.
FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS



Provider Locator: To find a PPO Provider in your service area or when traveling, please call: 1-800-810-BLUE (2583) or use the provider finder at www.bcbsil.com

To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.
To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.

Customer Service: 1-800-409-9462

BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.
24/7 Nurseline: 1-800-299-0274
Pharmacy Program: 1-800-423-1973

Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

 BlueCross BlueShield of Illinois 


DOE, JOHN

Identification No. XOF123456789

Copays:
Office Visit \$20
Emergency \$75

GROUP NUMBER P12345 BS Plan Code 621 BC Plan Code 121

Single DENTIF

 PRIME
BIN011552 Rx
PCN: ILDR

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.

BlueCare Connection (BCC): 1-800-572-3089

Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.
FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS

Provider Locator: To find a PPO Provider in your service area or when traveling, please call: 1-800-810-BLUE (2583) or use the provider finder at www.bcbsil.com

To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.
To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.

Customer Service: 1-800-409-9462

BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.
24/7 Nurseline: 1-800-299-0274
Pharmacy Program: 1-800-423-1973

Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

BlueChoice

Description

BlueChoice is a managed care, point-of-service product, offering members the choice to seek care within the BlueChoice network of providers and receive the highest level of benefits, or to go out of network and incur a lower level of benefits.

Each member who is enrolled in the BlueChoice program selects a participating Primary Care Physician (PCP) who provides services and coordinates all health care needs with BlueChoice Participating Specialist Physicians (PSPs) and other BlueChoice network providers.

Physician Network

BlueChoice physicians must be PPO contracted and have completed the BlueChoice application and contracts. BlueChoice contracted physicians must be board certified in their respective specialty or in the process of obtaining board certification at the time of reappointment.

Participating Specialist Physician (PSP) Network

A listing of PSPs can be found on the BCBSIL Provider Finder[®] at www.bcbsil.com. **Note:** Primary care physicians are required to refer to participating BlueChoice physicians for these specialties. All other specialty types are to be referred within the PPO network.

Hospital Network

A listing of BlueChoice network hospitals can be found on the BCBSIL website at <http://www.bcbsil.com/provider/standards/securedpage.html>. The PCP must notify the Plan of all services they order or authorize for a member by either calling the MSA to pre-certify or by submitting a properly completed referral form as indicated below. The referral fax number is (800) 852-1360.

Referrals

Services for Which a Referral Must Be Written:

- Specialist consultation
- Chiropractic services
- Durable Medical Equipment (DME)
- Physical, Speech and Occupational Therapy
- Emergency room visits (only when directed by the PCP)
- Podiatrists
- Diagnostic Testing (other than those that require pre-certification)
- Ultrasounds
- OB/GYN care for specific employer groups that do not have the option to select an OB/GYN PCP or Certified Nurse Midwife
- All other services which are not performed and billed by the PCP

Precertification

The following services must be pre-certified by calling **(800) 232-3476**:

- Inpatient admission
- Outpatient surgery (outside PCP office)
- Major diagnostic tests performed in the office or outpatient setting (CT-Scan, MRI, Angiogram, UGI Endoscopy, Laparoscopy, Arthroscopy, Colonoscopy, Cystoscopy)
- Home health services
- Home infusion
- Hospice care
- Skilled Nursing Facility admission
- Human organ transplants
- Obstetrical services – first trimester pregnancy and delivery
- Inpatient Rehabilitation

Laboratory Services

BlueChoice Primary Care Physicians (PCPs) and Participating Specialist Physicians (PSPs) may utilize any independent BCBS PPO contracted laboratory.

A listing of all contracting PPO labs can be found on our website at www.bcbsil.com, under Provider Finder® (specifically under “Other Provider Types”). If you refer a member to a non-contracting laboratory facility, the member will receive a lower level of benefits and will incur higher out-of-pocket expenses.

Important Reminders:

1. A referral form is **not** required for any laboratory services.
2. You may submit a claim for any venipuncture (CPT 36415) performed in your office.

Should you have questions or concerns regarding this notice, please contact the Interactive Voice Response (IVR) at (800) 972-8088 or your Provider Network Consultant.

Reimbursement to the PCPs for exempt laboratory services will be based on the reduced BlueChoice SMA.

PCPs may refer BlueChoice members requiring outpatient laboratory tests to BlueChoice network hospitals for:

- Outpatient stat laboratory tests – if results are required in less than two hours
- Pre-operative testing – if hospital requires on-site testing
- Direct Bilirubin and neonatal genetic screening including PKU
- For patients whose medical conditions warrant special consideration, patients receiving chemotherapeutic drugs, dialysis, etc.

The Participating Specialist Provider (PSP) is encouraged to utilize the BCBSIL PPO contracted laboratories. If a non-network laboratory is used and the PSP bills the Plan, the reimbursement is at the BlueChoice SMA.

Benefits

- **In-network benefits:** The highest level of benefits will apply
- **Out-of-network benefits:** A lower level of benefits will apply

Billing

BlueChoice providers:

- Must bill all services using the CMS-1500 format, either electronically or on paper.
- May collect any co-payment at the time of service.
- Should bill BCBSIL prior to collecting any fees other than copayments from the patient. After receiving the PCS, providers may bill the member for any applicable deductibles, coinsurance or non-covered services.
- May not balance bill the patient for any fees over the allowable charge.

Copayments

If the copayment is not listed on the member's insurance ID card, please access NDAS Online, call the Interactive Voice Response at (800) 972-8088 or call the BlueChoice Department at (312) 653-7433.

Deductibles & Coinsurance

Deductible and coinsurance amounts may vary for each contract. BlueChoice providers should not bill the member for deductible or coinsurance amounts prior to billing BCBSIL. These billable amounts will be listed on the PCS.

Reimbursement

Reimbursement is based on fee-for-service in accordance with the BlueChoice SMA. Additionally, PCP/PSPs are assigned a payment tier based on the following criteria:


- Quality Indicators
- Cost Efficiency

Performance Category (Payment Tier)	Description of Performance
Blue	Performance significantly higher than BlueChoice network norms.
White	Performance consistent with BlueChoice network norms.

BlueChoice Phone Number: (312) 653-7433

BlueChoice Identification Card

BlueChoice members are identified by the letter **M** in the third position of the alpha prefix (**XOM**), or a national account alpha prefix that relates to the group name, such as the ID card for A.M. Castle, AMC shown below:

 <p>BlueCross BlueShield of Illinois</p>		<h2>BlueChoice</h2>	
Subscriber:	Doe, Jane	Plan Codes:	121/621
Participant	Jane Doe	Group No.	123456
Identification Number:	XOM123456789	Copays:	
Participant's PCP Name:	Dr. John Smith	Office Visit	\$10
Participant's 2nd PCP Name:	Dr. Mary Jones	Emergency	\$50
		PCP Effective Date	01-01-09
		2nd PCP Effective Date	01-01-09
		PRIME	
		BIN011552	
		PCN ILDR	

To the Member: To receive the highest level of in-network benefits, all medical care must be provided or authorized by your Primary Care Physician (PCP). Out-of-network care not authorized by your PCP will be paid at a reduced level of benefits and you will be responsible for precertifying the care.

Out-of-Network Hospital Admission: To avoid further benefit reductions, you must call the Medical Support Department at least one business day prior to elective admissions and skilled nursing care, private duty nursing and home care or within two business days of an emergency admission. For maternity, call as soon as pregnancy is confirmed and within two business days of admission. **1-800-972-9357.**

Mental Health/Chemical Dependency Treatment: Call Mental Health/Chemical Dependency to precertify, any in- or out-of-network care. Call within 48 hours of a mental health emergency. **1-800-851-7489.**

To Hospital/Physician: For out of network claims, please call Customer Service. All other hospitals and physicians should file claims to your local BlueCross BlueShield Plan.

Customer Service: 1-800-409-9462

Pharmacy Program: 1-800-423-1973

For claims information via the internet: www.bcbsil.com

BlueCross BlueShield of Illinois, an independent licensee of the BlueCross and BlueShield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

 <p>BlueCross BlueShield of Illinois</p>		 <p>Castle Metals</p>	
		<p>BlueChoice</p>	
Subscriber	Doe, Jane	Plan Codes:	621/121
Participant	Jane	Group No.	081732
Identification Number	AMC123456789	Copays:	
Participant's PCP Name	Dr. John Smith	Office Visit	\$15
Participant's 2nd PCP Name	Dr. Mary Jones	Emergency	\$50
		PCP Effective Date	01-01-09
		2nd PCP Effective Date	01-01-09

To the Insured: To receive the highest level of in-network benefits, all medical care must be provided or authorized by your Primary Care Physician (PCP). Out-of-network care not authorized by your PCP will be paid at a reduced level of benefits and you will be responsible for precertifying the care.

Out-of-Network Hospital Admissions: To avoid further benefit reductions, you must call the Medical Support Department at least one business day prior to elective admissions and within two business days of an emergency admission. For maternity, call as soon as pregnancy is confirmed and within two business days of admission. **1-800-972-9357**

Healthy Expectations: 1-800-824-3095

Mental Health/Substance Abuse Treatment: Call Mental Health Client Services to precertify any in- or out-of-network care. Call within 48 hours of a mental health emergency. **1-800-851-7498.**

To Hospital/Physician: Illinois Hospitals and Physicians should file claims in the usual manner to:

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

All other hospitals and physicians should file claims to the local Blue Cross and Blue Shield Plan.

CUSTOMER SERVICE: 1-800-458-6024

BlueChoice Select

Description

BlueChoice Select is an open access health care program, offering members the choice to self-direct their care within the BlueChoice network of providers or to seek services from an out-of-network provider.

Members seeking care from the BlueChoice network of participating physicians and facilities will receive in network benefits reimbursed at the higher benefit level. Care obtained from a physician or facility not participating in the BlueChoice network will be considered out-of-network, and available benefits will be reimbursed at a lower level.

Physician Network

The BlueChoice physician network is the same as it is for both the BlueChoice and BlueChoice Select products. Physicians must be PPO contracted and have completed the BlueChoice application and contracts. BlueChoice contracted physicians must be board certified in their respective specialty or in the process of obtaining board certification, and must have admitting privileges to one of the BlueChoice hospitals.

Participating PCPs must be board certified in one of the following specialties:

- Family Practice
- Internal Medicine
- Pediatrics
- Obstetrics/Gynecology

Participating Specialist Physician (PSP) Network

A listing of PSPs can be found on the BCBSIL Provider Finder[®] at www.bcbsil.com. **Note:** Primary care physicians are required to refer to participating BlueChoice physicians for these specialties. All other specialty types are to be referred within the PPO network.

Hospital Network

A listing of BlueChoice network hospitals can be found on the BCBSIL Provider Finder[®] at www.bcbsil.com.

Referrals

No referral is needed to see a specialist or to obtain another opinion about a medical condition. However, when a referral is necessary, every effort must be made to refer to in-network participating BlueChoice providers for members to receive the highest level of benefits. BlueChoice Select members will not be required to visit or consult their primary family physician before seeking care, and, as such will not require a referral to see a provider. In the event a member does see their family physician, and is directed to a provider not participating in the network, the claim would be paid at an out-of-network payment level.

Precertification

Pre-certification requirements are the same as those which currently exist under the PPO program. BlueChoice Select requires plan notification and approval for inpatient hospital admissions, Skilled Nursing Facility (SNF) admissions, Coordinated Home Care (CHC), Private Duty Nursing (PDN) and solid organ transplants. Network providers are responsible for contacting the Medical Management Department regarding all services which require precertification.

The recommended timeframe for pre-certification is 1 day prior to an elective admission and within 2 days following an emergency admission. The toll-free Medical Management number and notification requirements can be found on the back of the member's ID card. If the member or physician does not call within the required timeframe, the member's benefits may be reduced and they may have higher out-of-pocket costs.

For non-network or out-of-state admissions, pre-certification is the member's responsibility.

Laboratory Services

BlueChoice Select PCPs and PSPs may utilize any independent BCBSIL PPO contracted laboratory.

A listing of all contracting PPO labs can be found on our website at www.bcbsil.com, under Provider Finder[®] (specifically under "Other Provider Types"). If you refer a member to a non-contracting laboratory facility, the member will receive a lower level of benefits and will incur higher out of pocket expenses. This change applies to PCPs only.

Important Reminders:

1. A referral form is **not** required for any laboratory services.
2. You may submit a claim for any venipuncture (CPT 36415) performed in your office.

Should you have questions or concerns regarding this notice, please contact the Provider Telecommunications Center at (800) 972-8088 or your Provider Network Consultant.

PCPs may refer BlueChoice members requiring the following outpatient stat laboratory tests to BlueChoice Network Hospitals if the results are required in less than two hours

- Pre-operative testing – if hospital requires on-site testing
- Direct Bilirubin and neonatal genetic screening including PKU
- Patients whose medical conditions warrant special consideration, patients receiving chemotherapeutic drugs, dialysis, etc.

The PSP is encouraged to utilize BCBSIL PPO contracted laboratories. If a non-network laboratory is used and the PSP bills the Plan, the reimbursement is at the BlueChoice SMA.

Benefits

- **In-network benefits:** The highest level of benefits will apply
- **Out-of-network benefits:** A lower level of benefits will apply

Billing

BlueChoice providers:

- Must bill all services using the CMS-1500 format, either electronically or on paper.
- May collect any copayment at the time of service.
- Should bill BCBSIL prior to collecting any fees other than copayments from the patient. After receiving the PCS, providers may bill the member for any applicable deductibles, coinsurance or non-covered services.
- May not balance bill the patient for any fees over the allowable charge.

Copayments

If the copayment is not listed on the member's insurance ID card, please:

- Access NDAS Online
- Call the Interactive Voice Response (IVR) at (800) 972-8088, or
- Call the BlueChoice Select Department at (312) 653-7433.

Deductibles & Coinsurance

Deductible and coinsurance amounts may vary for each contract. BlueChoice providers should not bill the member for deductible or coinsurance amounts prior to billing BCBSIL. These billable amounts will be listed on the PCS.

Reimbursement

Reimbursement is based on fee-for-service in accordance with the BlueChoice SMA. Additionally, PCPs and PSPs are assigned a payment tier based on the following criteria:




- Quality Indicators
- Cost Efficiency

Performance Category (Payment Tier)	Description of Performance
Blue	Performance significantly higher than BlueChoice network norms.
White	Performance consistent with BlueChoice network norms.

BlueChoice Select Phone Number: (312) 653-7433

BlueChoice Select Identification Card

BlueChoice Select members are identified by the letter **U** in the third position of the alpha prefix (**XOU**), or a national account alpha prefix that relates to the group name, such as the ID card for A.M. Castle, AMC shown below:

		BlueCross BlueShield of Illinois	BlueChoice Select
Subscriber DOE, JOHN			
Identification No.		XOU112223333	
Group No. OM9930		Plan Codes 121/621	
		PRIME BIN011562 PCN:ILDR 	

		BlueCross BlueShield of Illinois	
BlueChoice			
Subscriber Doe, Jane		Plan Codes: 621/121	
Participant Jane		Group No. 081732	
Identification Number AMC123456789		Copays: Office Visit \$15 Emergency \$50	

To the Insured: To receive the highest level of in-network benefits, all medical care must be provided or authorized by your Primary Care Physician (PCP). Out-of-network care not authorized by your PCP will be paid at a reduced level of benefits and you will be responsible for precertifying the care.

Out-of-Network Hospital Admissions: To avoid further benefit reductions, you must call the Medical Support Department at least one business day prior to elective admissions and within two business days of an emergency admission. For maternity, call as soon as pregnancy is confirmed and within two business days of admission.
1-800-972-9357

Healthy Expectations: 1-800-824-3095

Mental Health/Substance Abuse Treatment: Call Mental Health Client Services to precertify any in- or out-of-network care. Call within 48 hours of a mental health emergency. **1-800-851-7498.**

To Hospital/Physician: Illinois Hospitals and Physicians should file claims in the usual manner to:

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

All other hospitals and physicians should file claims to the local Blue Cross and Blue Shield Plan.
CUSTOMER SERVICE: 1-800-458-6024

Blue Cross Blue Shield of Illinois HMOs

Description

BCBSIL offers HMO Illinois (HMOI) and BlueAdvantage (BA) HMO. HMOI was our first managed care product, for large employer groups. BlueAdvantage HMO was originally developed for smaller employer groups with 100-250 employees. Members have the same benefits as those in HMOI. HMO offers a full range of comprehensive health benefits while focusing on cost savings, preventive care and wellness for members. Members must choose a PCP from an HMO contracted IPAs. The PCP manages all aspects of medical care by providing or arranging for all necessary professional and ancillary services, within the scope of the various benefit plans.

Physician Network

BCBSIL HMOs contract with IPAs; IPA means an Individual Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provisions of professional medical services.

- Medical Group: Physicians who practice out of the same medical facility
- Individual Practice Association/ Independent Physician Association (IPA): Groups of physicians who have fulfilled the legal requirements to form their own corporation, but who practice out of different locations
- Physician Hospital Organization (PHO): An organization owned and governed jointly by a hospital and its physicians

The member must choose a PCP from one of the HMO IPA contracted groups. A directory of participating providers is given to HMO providers and members. This directory is updated three times a year, as participating providers are added to the HMO network. You may verify current information by calling your IPA or access our Provider Finder[®] at www.bcbsil.com.

Facility Network

The HMO member must be referred by their PCP to a facility within the HMO contracted network. The facility network of participating providers includes the following provider types:

- Hospitals
- Skilled Nursing Facilities
- Surgi-Centers
- Free Standing Chemical Dependency Centers
- Home Health Agencies
- Hospices
- Home Infusion Providers
- Durable Medical Equipment Suppliers
- Infertility Centers
- Prosthetics/Orthotics Providers

Referrals

The member's PCP must authorize, in writing, medical referrals to facilities or specialists. If members seek treatment on their own, they are responsible for the cost. However, a referral is not needed when a medical emergency exists.

Mental health care must also be coordinated through the member's PCP. Chemical dependency care is self-referred and does not have to be referred through the PCP. Members requiring services must use the chemical dependency network by calling **(800) 346-3986**. A medical professional assesses the situation and directs the member to a contracted facility.

Precertification Requirements

All services must have IPA approval.

Benefits

- **Group Approval:** Comprehensive benefits, within the scope of the benefit plan, are paid when medical care is given by the member's PCP or for referral care that has been authorized by the PCP.
- **Non-Group Approval:** Medical care that is not provided or authorized by the PCP is considered Non-Group Approved, and is not covered. The only exception would be in a medical emergency.

Benefit plans within the HMO product vary, with each member or employee plan being different in respect to specific covered benefits. Providers may access NDAS Online to obtain specific benefits or call the Interactive Voice Response (IVR) at **(800) 972-8088**.

Copayments

Certain HMO benefit plans have a copayment for office visits, emergency room visits or outpatient visits. You may access NDAS Online to determine the copayment amount.

HMO Claim Processing

Group Approval Process (GAP)

The Group Approval Process (GAP) contract is a formal contractual agreement between a HMO IPA, a hospital and BCBSIL HMO that facilitates the process of obtaining IPA approval for inpatient hospitalization and outpatient ambulatory surgery. This agreement enables the HMO claim department to process the UB-04 without a written stamped approval from the IPA. Only hospitals with signed contracts can utilize Form Locator “63” (Treatment Authorization Code) of the UB-04 with the code word “GAP.”

To avoid unnecessary delays when filing claims, we are providing you with:

- The HMO Claim Processing Work Flow (with and without a GAP contract).
- A Financial Risk Split Table that outlines the reimbursement responsibility of the IPA and the HMO for medical services.

All IPAs interested in pursuing this contract with their affiliated hospitals should contact their Provider Network Consultant. Similarly, hospitals interested in contracting with their affiliated IPAs should contact their Provider Network Consultant.

HMO COB Process

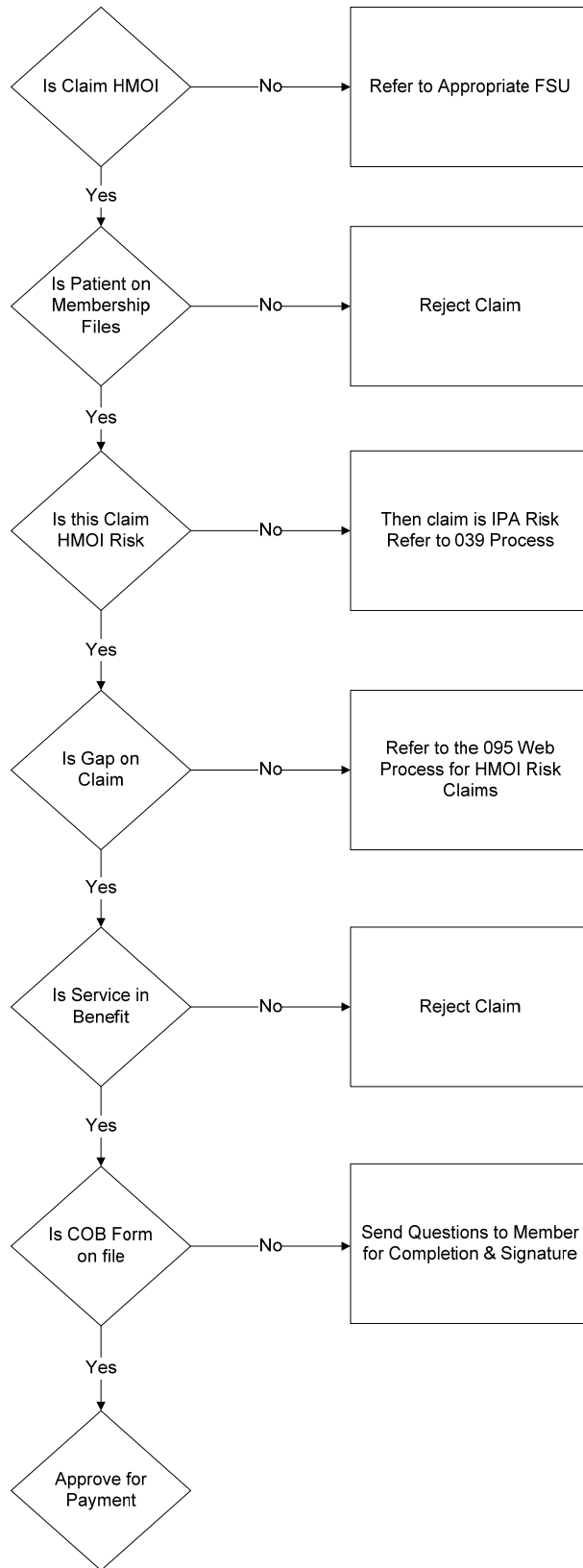
A claim is pended for Coordination of Benefits (COB) when the claim is for the spouse or a dependent and we do not have other coverage information on file, or the information needs to be updated based on the time frame programmed in our system. The claim will pend and a letter and questionnaire (CSQ) are generated. The claim is held open for 21 days to allow receipt of the COB information. If not received within that time frame, the claim is closed. Upon receipt of the requested information we will consider payment on the claim.

The following are acceptable methods to submit this information:

- The *member* returns the CSQ, completing all of the information that applies to their situation.
- The *member* may also contact our customer service department and provide the requested information, or complete the CSQ online and submit it to us through Blue Access for Members on our website. We will load and/or update the file, completing the adjudication process.
- A *provider* may submit via fax or mail, their own COB form as long as it contains all the same information as our form and is signed by the patient. The member’s group and certificate number must be on the COB form. Forms may be faxed to (815) 987-5385.

Note: If a provider completes our CSQ form on behalf of the member, the original form we mailed to the member must be used.

HMO Claim Processing Flow Chart



Reimbursement

The chart below outlines the reimbursement responsibility for the IPA and the HMO. Contracted IPAs are paid a monthly capitation fee for all HMO members enrolled with their group. The IPA uses these funds to pay for IPA responsibility services. Reimbursement information for facilities and other benefits that are the responsibility of the HMO are covered in the Billing and Reimbursement Section.

HMO Responsibility	IPA Responsibility*
<ul style="list-style-type: none"> ▪ Facility charges for: <ul style="list-style-type: none"> -Inpatient stays -Outpatient surgery -Out of area -Emergency Room visit ▪ Observation Units ▪ Professional Emergency Admission - Charges prior to IPA notification ▪ Professional charges for out of area emergency room visits ▪ Hospice ▪ Skilled Nursing Facility ▪ All charges for: <ul style="list-style-type: none"> -Extraction of fully bony impacted teeth -Voluntary Sterilization -Organ Transplants (approved by HMO) ▪ Prescription Drugs ▪ Vision Exam/Eyewear ▪ Chemical Dependency (If referred to HMO Network Provider) ▪ Durable Medical Equipment (If referred to HMO Network Provider) ▪ Skilled Home Health (If referred to HMO Network Provider) ▪ Orthotics/Prosthetics (O&P) (If referred to HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Medical Supplies (not from an MD office) ▪ Ground Ambulance ▪ ART/Infertility (If referred to HMO Network Provider) ▪ Dialysis (if referred to HMO Network Provider) 	<ul style="list-style-type: none"> ▪ Professional Fees for: <ul style="list-style-type: none"> -Inpatient -Outpatient -In area Emergency Room visit ▪ Outpatient Diagnostics ▪ Outpatient Rehabilitation ▪ Medical Supplies from MD office ▪ Injections ▪ Immunizations ▪ Well Child Care ▪ Outpatient Mental Health ▪ Periodic Health Exams ▪ Dental - see Section II, C.2 of MSA ▪ Orthotics/Prosthetics (O&P) (If referred to Provider other than HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Outpatient Radiation and Chemotherapy ▪ Outpatient Inhalation (Respiratory) Therapy ▪ Outpatient Hearing Screening ▪ Outpatient Ancillary Services ▪ Outpatient treatment ▪ ART/Infertility (If referred to Provider other than HMO Network Provider) ▪ Durable Medical Equipment (if referred to Provider other than HMO Network Provider) ▪ Skilled Home Health (if referred to Provider other than HMO Network Provider or for an Ambulatory member) ▪ Chemical Dependency Professional Charges (if referred to Provider other than HMO Network Provider)



Note: This list is not all inclusive.

HMO Phone Numbers

Customer Service/Membership/Benefits:	(800) 972-8088
Customer Assistance Unit:	(312) 653-6600
Chemical Dependency:	(800) 346-3986
Provider Claims:	(800) 972-8088

Blue Cross Blue Shield of Illinois HMOs Identification Card

HMO members are identified by the letter **H** or **B** preceding the group number, and the alpha prefix (**XOH**) on their ID card.

		BlueCross BlueShield of Illinois		HMO Illinois A Blue Cross HMO	
Subscriber SMITH, Mary		www.bcbsil.com			
Participant's Name Mary Smith		Group No. H12345			
Identification No. XOH851234435		Copays: Office Visit \$10 Emergency \$50		Benefit Plan: B3E10 Plan Codes: 621/121	
Medical Group Number & Name 125 ABC MEDICAL CENTER (708) 444-4444 01-01-09		WPHCP 125 ABC MEDICAL CENTER (708) 444-4444 01-01-09		PRIME BIN: 011552 PCN: ILDR	
					

“Empty Suitcase” Logo
This identifies BlueCard members who receive benefits other than PPO benefits, for example Traditional, POS and HMO

IN CASE OF EMERGENCY -- CALL YOUR MEDICAL GROUP/PRIMARY CARE PHYSICIAN PHYSICIAN

TO HOSPITALS OR PHYSICIANS: The enrollee named on the face of the card, while currently enrolled, is entitled to benefits. All medical and hospital services, except emergencies, must be pre-authorized by the Medical Group/Individual Practice Association (IPA) named on the face of this card.

TO HOSPITALS OR PHYSICIANS: Please file claims with your local BlueCross BlueShield Plan.

TO MEMBER: If a provider does not submit your claim on your behalf, please file the claim to the address listed below. To locate a provider when you are out of your service area or when traveling call the BlueCard Access number listed below.

Customer Service #: 1-800-892-2803

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Chemical Dependency Network #: 1-800-346-3986

BlueCard Access #: 1-800-810-BLUE

Pharmacy Program #: 1-800-423-1973

BlueCard Provider Eligibility #: 1-800-676-BLUE

HMO-WPHCP-w/Rx
QB4103




Provider Locator Number
A toll-free telephone number that members can use to locate providers in the BCBS Plan's area.

BlueCard Eligibility Number
Providers can call this telephone number to verify membership and coverage.

BlueAdvantage HMO

BlueAdvantage HMO is a Blue Cross and Blue Shield product for today's small businesses. BlueAdvantage HMO operates similarly to HMOI but with a smaller HMO network. It appeals to smaller business by offering a more affordable program.

BlueAdvantage HMO ID card

		BlueAdvantage HMO	
Subscriber SMITH, JOSEPH		Group No. B12345	
Participant's Name JANE		Benefit Plan: BLADV	
Identification No. XOH12345689		Plan Codes: 621/121	
Medical Group Number & Name 125 ABC MEDICAL GROUP (708) 444-4444 09-01-09		PRIME BIN:011552  	
WPHCP 125 ABC MEDICAL GROUP (708) 444-4444 09-01-09		Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, Illinois 60680-4112	
		Customer Service: 1-800-892-2803 Pharmacy Network information: 1-800-410-8823	

IN CASE OF EMERGENCY - CALL YOUR MEDICAL GROUP/PRIMARY CARE PHYSICIAN TO HOSPITALS OR PHYSICIANS: The enrollee named on the face of this card, while currently enrolled, is entitled to benefits. All medical and Hospital services, except in life-threatening, severe emergencies, or out-of-area emergencies must be pre-authorized by the Medical Group/Individual Practice Association (IPA) named on the face of this card.

TO HOSPITAL: Hospital should follow its regular procedure for reporting services rendered to the enrollee named (or covered dependent) by contacting its local Blue Cross Plan. Hospitals may report services to the address below.

TO PHYSICIAN: Upon completion of Physician's Service Report, this HMO pays physicians for certain emergency services rendered to the enrollee (or covered dependents). Non-emergency services are provided by the Medical Group/Individual Practice Association (IPA) named on the face of this card. Mail reports to the address below. Be sure to include the Group Number and Identification Number appearing on the face of this card.

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112
Customer Service: 1-800-892-2803
Pharmacy Network information: 1-800-410-8823

Federal Employees Program (FEP)

Description

The Blue Cross and Blue Shield Association (BCBSA) has contracted with the Office of Personnel Management (OPM) to provide a health benefit plan that is authorized by the Federal Employees Health benefits (FEHB) law. The FEHB law specifies the manner in which the health benefits plan is administered. The FEP Program offers two benefit options: Standard Option and Basic Option health benefit plans.

Basic Option

The Basic Option health benefit plan is an **in-network only benefit program**. This means FEP members who have the Basic Option benefit plan must use PPO network providers to receive coverage. There is no coverage when a Basic Option member uses a non-PPO provider. The Basic Option plan has a different co-pay for PPO Primary Care Providers and Specialists. The co-pays are twenty-five dollars (\$25) for Primary Care Providers and thirty dollars (\$30) for Specialists. For the FEP Plan, Primary Care Providers include general practitioners, family practitioners, medical internists, pediatricians, and obstetricians/gynecologists.

Basic Option Highlights

- Must use PPO providers
- No out-of-network benefits (the only exceptions are medical emergency and accidental injury care in a hospital emergency room)
- Co-pays apply to most services
- No deductibles
- Chiropractic coverage included
- Three-tier pharmacy benefit
- Preventive dental
- Preferred retail pharmacy program

Standard Option

The standard Option health benefit plan offers a PPO program that consists of a nationwide network including PPO hospitals, physicians, podiatrists, dentists, pharmacies, mental health facilities and laboratories. FEP members who have the Standard Option Plan must use PPO providers to receive comprehensive benefits. Standard Option members may choose to use Non-Participating providers, but this will result in a reduction of benefits.

Standard Option Highlights

- Using PPO providers pays comprehensive benefits, (85% of covered services)
- Using Out-of-Network providers results in a reduction of benefits (70% of covered services)
- \$20 co-pay for office visits

Professional Provider Network

The physician network that Basic Option and Standard Option utilize is the standard PPO network. PPO network eligible providers include:

- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Surgical Assistants (CSAs)
- Certified Surgical Technologists (CSTs)
- Chiropractors
- Clinical Psychologist
- Durable Medical Equipment
- Home Infusion
- Independent Lab
- Licensed Clinical Nurse Specialist
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist
- Optometrists
- Orthotics
- Osteopaths
- Physicians
- Podiatrists
- Prosthetics
- Registered Nurse First Assistants (RNFAs)
- Registered Surgical Assistants (RSAs)
- Sleep Medicine
- Surgical Assistants Certified (SACs)
- Therapist (Physical, Speech, Occupational)

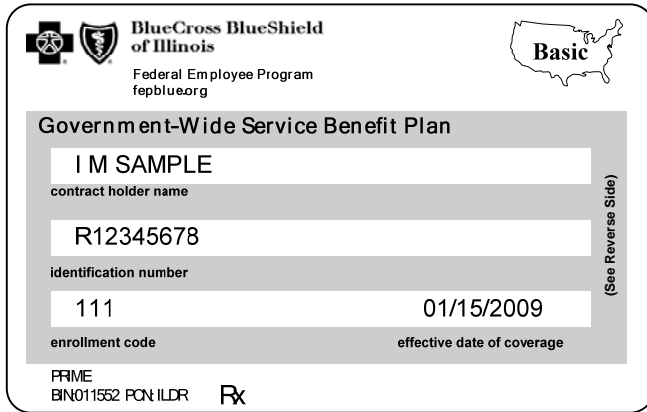
Facility Provider Network

The facility network that both Basic Option and Standard Option utilize are the PPO hospitals, mental health facilities, laboratories, and pharmacies.

PPO contracted facilities consist of the following network provider types:

- Hospitals
- Coordinated Home Care (CHC)
- Hospice
- Skilled Nursing Facility (SNF)
- Surgi-Centers
- Renal Facilities
- Free Standing Psychiatric and Chemical Dependency Facilities

Basic Option Health Insurance Card Identification



BlueCross BlueShield of Illinois
Federal Employee Program
fepblue.org

Basic

Government-Wide Service Benefit Plan

I M SAMPLE
contract holder name

R12345678
identification number

111
enrollment code

01/15/2009
effective date of coverage

PRIME
BIN011552 PCN ILDR Rx

(See Reverse Side)

This card is used to obtain covered benefits under the Blue Cross and Blue Shield Service Benefit Plan Basic Option. **You MUST use Preferred providers to get benefits.** Precertification is required for all hospital admissions and is ultimately your responsibility. For information, call the local Blue Cross and Blue Shield Plan serving the area where you are treated. **Prior approval for outpatient mental health/substance abuse services is required.**

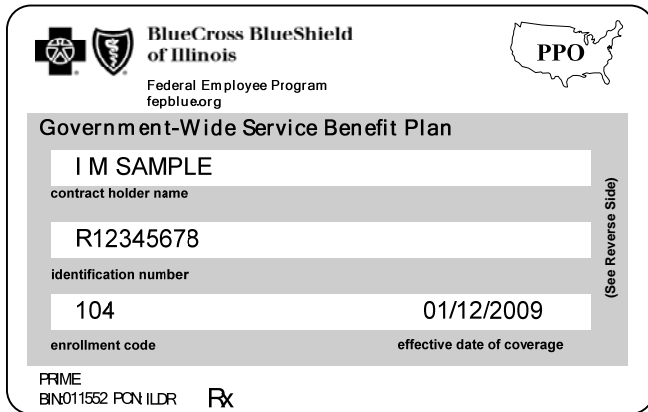
For Customer Service	1-800-XXX-XXXX
For Precertification	1-800-XXX-XXXX
For Mental Health/Substance Abuse (prior approval required)	1-800-XXX-XXXX
Retail Pharmacy Information (fepblue.org)	1-800-624-5060
Blue Health Connection Information	1-888-258-3432
Assistance Overseas (call collect)	1-800-673-1678

Use of this card constitutes acceptance of the terms and conditions of the Service Benefit Plan Brochure (RI 71-005) for the applicable contract year, which is the only legal description of benefits.

Enrollment Codes	Office Visit Co-Payments
111 Basic Option – Self Only	\$25 – Primary Care Providers
112 Basic Option – Self and Family	\$30 – Specialists

Each Plan's precertification procedures and phone numbers will be customized for members in their area (refer to back of ID card). Precertification is required by hospitals for inpatient admissions. Failure to do so will result in a \$500 penalty.

Standard Option Health Insurance Card Identification



BlueCross BlueShield of Illinois
Federal Employee Program
fepblue.org

PPO

Government-Wide Service Benefit Plan

I M SAMPLE
contract holder name

R12345678
identification number

104
enrollment code

01/12/2009
effective date of coverage

PRIME
BIN011552 PCN ILDR Rx

(See Reverse Side)

This card may be used for covered Hospital, Surgical, Medical, Dental and Prescription Drug Benefits:

When you go to a Preferred hospital, precertification will be done for you. You must call for precertification when using other hospitals. If care is received outside your local area, please contact the Blue Cross and Blue Shield Plan serving that area.

HELPFUL TELEPHONE NUMBERS

For Customer Service	1-800-XXX-XXX
For Precertification	1-800-XXX-XXX
*Pharmacy Claim Information	
For Retail Pharmacy	1-800-624-5060
For Mail Order Pharmacy	1-800-262-7890

Use of this card constitutes acceptance of the terms and conditions of the Service Benefit Plan Brochure (RI 71-5). All benefits are subject to the definitions, limitations and exclusion set forth in the Brochure for the applicable contract year, which is the only legal description of benefits.

Enrollment Codes	Office visit Co-Payment
104 Standard Option – Self Only	\$20
105 Standard Option – Self and Family	\$20

Each Plan's precertification procedures and phone numbers will be customized for members in their area (refer to back of ID card). Precertification is required by hospitals for inpatient admissions. Failure to do so will result in a \$500 penalty.

Illinois Comprehensive Health Insurance Plan (ICHIP)

Description

The Illinois Comprehensive Health Insurance Plan (ICHIP) is offered to certain Illinois residents who have been denied major medical coverage by private insurers. Traditional ICHIP is offered to eligible residents who can afford insurance but are unable to find major medical insurance coverage in the private market due to a pre-existing health condition or disability. The Illinois Comprehensive Health Insurance Plan Board Office underwrites ICHIP policies. State appropriations subsidize the cost of the plan and BCBSIL administers the program.

ICHIP also offers coverage to Illinois residents who are considered federally eligible for coverage under HIPAA. These HIPAA eligible individuals have—for various reasons—lost their group insurance or exhausted COBRA benefits, and are guaranteed ICHIP coverage when they meet timely enrollment and eligibility requirements. The ICHIP Board Office also underwrites these policies, and funding is provided by health insurers and HMOs who do business in Illinois.

ICHIP Benefit Plans

- Traditional ICHIP coverage provides a PPO Plan for members who are not Medicare eligible. These members have a six-month pre-existing condition waiting period. ICHIP members who have the PPO Plan receive comprehensive benefits when they use PPO providers. If ICHIP PPO members use out-of-network providers there will be a reduction of benefits.
- ICHIP coverage provided to HIPAA eligible members is also a PPO plan. There is no pre-existing condition limitation for this coverage. These members receive comprehensive benefits when they use PPO providers. There is a reduction in benefits if out-of-network providers are used.
- ICHIP provides a Medicare carve out plan for persons who are under age 65 and who are also eligible for Medicare. This plan is somewhat unique in that ICHIP is always the payer of last resort (secondary payer to Medicare or other allowed coverage).
- ICHIP High Deductible Health Plans are available to persons who qualify for coverage under the Traditional ICHIP plan or the HIPAA eligible plan. All HDHPs are PPO plans. An important difference between the HDHP plans and the other HDHP plans is that in the HDHP plans all charges are subject to the deductible including prescription drugs, pre-admission testing and second surgical opinions.

Professional Provider Network

Providers must have a valid state license in Illinois, or in the state in which they render service to BCBSIL members, have signed the MPP contract and the PPO Plus Addendum contract. To confirm PPO participation in the PPO network use the Provider Finder[®] on our website at www.bcbsil.com. PPO network eligible providers are:

- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Surgical Assistants (CSAs)
- Certified Surgical Technologists (CSTs)
- Chiropractors
- Clinical Psychologist
- Durable Medical Equipment
- Home Infusion
- Independent Lab
- Licensed Clinical Nurse Specialist
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist
- Optometrists
- Orthotics
- Osteopaths
- Physicians
- Podiatrists
- Prosthetics
- Registered Nurse First Assistants (RNFAs)
- Registered Surgical Assistants (RSAs)
- Sleep Medicine
- Surgical Assistants Certified (SACs)
- Therapist (Physical, Speech, Occupational)

Facility Provider Network

PPO contracted facilities consist of the following network provider types:

- Hospitals
- Coordinated Home Care (CHC)
- Hospice
- Skilled Nursing Facility (SNF)
- Surgi-Centers
- Renal Facilities
- Free Standing Psychiatric and Substance Abuse Facilities

Precertification Requirements

Medical Management will perform pre-admission review of confinement in a hospital or a skilled nursing facility. Either the member or physician can call the Medical Management Department at **(800) 232-6179** for precertification. It is the member's responsibility to assure that precertification is obtained. The member, the physician and the hospital will be sent written notice of any period of confinement that has been certified as medically appropriate. If a phone call is not made, the member's benefits will be reduced by \$500. Durable Medical Equipment (DME) exceeding \$500 must also be pre-certified. If no call is made, then no benefits are payable for DME.

Additionally, precertification is required for Home Health Care, Human Organ Transplantation and Chemical Dependency. If these services are not precertified, benefits will not be paid.

Hospital Precertification Time Frames

Elective inpatient hospital stay
Emergency inpatient hospital stay





Within 7 days prior to admission
Within 48 hours after a weekday admission or, within 72 hours after an admission on a weekend or legal holiday

Referrals

When a referral for a covered member is necessary, the provider must make every effort to refer the member to in-network PPO providers, hospitals, and laboratories that are required by some contracts. Referrals to out-of-network providers could result in reduced benefits for the member. To confirm PPO participation use the Provider Finder[®] on our website at www.bcbsil.com.

For specific benefit information, providers can access NDAS Online or call the Provider Telecommunications Center (PTC) at (800) 972-8088.

Members with Prescription Coverage

		
As Administrator for Illinois Comprehensive Health Insurance Plan		
Doe, John M.		
Identification No.	RPX111223333	
Plan Codes 621/121		
Group No.	00PHPC	Rx Benefits Provided By: WHI RxBIN: 603286 RxFQN: 01410000 RxGroup: 514979 Issuer: 80840
		

TO THE PARTICIPANT: Medical Precertification is required prior to hospitalization, skilled nursing facility, home health care, some durable medical equipment and private duty nursing services, or within two (2) business days of an admission for emergency or maternity care. **WARNING:** If you receive or are approved to receive other medical benefits through the State of Illinois, you may be ineligible for ICHIP.

MEDICAL PRECERTIFICATION: 1-800-232-6179
MENTAL HEALTH/CHEMICAL DEPENDENCY: 1-800-851-7498

Failure To Contact Either Medical Precertification Or Mental Health Chemical Dependency Unit May Reduce your Available Benefits.

To find a participating PPO Provider call: 1-800-810-BLUE (2583).

To Hospitals/Physicians: Please file all claims with your local Blue Cross and Blue Shield Plan.

CUSTOMER SERVICE: 1-800-367-6410
Hearing Impaired: 1-800-545-2455
WHI Prescription Customer Care Center: 1-800-207-2568

This card is provided by Blue Cross and Blue Shield of Illinois, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Illinois provides administrative services only.

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

Members without Prescription Coverage

		
As Administrator for Illinois Comprehensive Health Insurance Plan		
Doe, John M.		
Identification No.	XOT111223333	
Plan Codes 621/121		
Group No.	00CHIP	

TO THE PARTICIPANT: Medical Precertification is required prior to hospitalization, skilled nursing facility, home health care, some durable medical equipment and private duty nursing services, or within two (2) business days of an admission for emergency or maternity care. **WARNING:** If you receive or are approved to receive other medical benefits through the State of Illinois, you may be ineligible for ICHIP.

MEDICAL PRECERTIFICATION: 1-800-232-6179
MENTAL HEALTH/CHEMICAL DEPENDENCY: 1-800-851-7498

Failure To Contact Either Medical Precertification Or Mental Health Chemical Dependency Unit May Reduce your Available Benefits.

To find a participating PPO Provider call: 1-800-810-BLUE (2583).

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CUSTOMER SERVICE: 1-800-367-6410
Hearing Impaired: 1-800-545-2455

This card is provided by Blue Cross and Blue Shield of Illinois, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Illinois provides administrative services only.

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

Medicare Supplemental

Description

BCBSIL Medicare supplemental policies are available to Illinois residents age 65 and over who are covered under Medicare Parts A and B, and who either do not have individual Medicare Supplemental coverage, or are replacing an existing policy. The Medicare Supplemental coverage helps pay for medical expenses that are not covered by Medicare. For Part A alone, these expenses could total over \$35,000.

“Standardization,” which began in 1992, requires that all insurers selling Medicare Supplemental coverage must sell only plans designed by the National Association of Insurance Commissioners (NAIC). There are ten standard plans that are designated A through L however, each insurer is not required to sell all ten plans. Insurers are allowed to name the plan they sell as long as one of the letters A through L is included in the name. This enables the consumer to identify and compare plans easily. A number of BCBSIL members, who were covered by plans designed prior to Standardization, have opted to retain their former coverage; therefore, the former plans will not contain the letters A through L.

BCBSIL Supplemental Plans

BCBSIL Standard Option Plans

- Ages 65-80+ - Plans A, B, C, D, E, F, High Deductible F, K, and L

BCBSIL Medicare Select Plans:

- Ages 65-80+ - Med-Select Plans B, C, D, E, F, K and L

Providers

For Standard Option Plans, members can choose their own doctors and hospitals for treatment.

For Med-Select Plans, members can choose their own doctors for treatment. In order to receive the benefit of having the Part A inpatient hospital deductible waived for Part A non-emergency hospital admissions, members must use the Med-Select hospital network. For emergency care inpatient admissions, the hospital deductible is waived at in-network hospitals and paid by BCBSIL at out-of-network hospitals.

2010 Medicare Supplement Benefit Matrices

To review the 2009 Medicare Supplement Benefit Matrices, visit our Provider website at http://www.bcbsil.com/provider/education/tutorials_user_guides.html.

Billing

Medicare providers are required by Federal law to file their Medicare claims with Medicare. For BCBSIL Medicare Supplemental, there are no claim forms to complete. In most cases claim filing is handled through the crossover system in which BCBSIL participates. Crossover is the automatic process in which Medicare, after claim adjudication, sends claim information to private insurers.

Professional Reimbursement

If a Medicare B provider accepts Medicare assignment, the provider agrees to charge the beneficiary/member no more than the Medicare approved amount. If a Medicare B provider does not accept Medicare assignment, the beneficiary/member is usually responsible for paying the difference between the Medicare approved amount and the billed amount. Due to Federal legislation, as of January 1, 1993, the Medicare B provider who does not accept assignment may only charge up to 15% (excess charge) above the Medicare approved amount. Plans F and Med-Select F will pay the excess charge.



BCBSIL Medicare Supplemental generally “follows Medicare’s suit.” If Medicare paid the provider directly, BCBSIL will also pay the provider directly. This usually occurs in cases where the doctor accepts Medicare assignment.

Facility Reimbursement

Reimbursement information for facilities is covered in the Billing and Reimbursement Section.

Member Services

(800) 624-1723

			
<p>DOE, JOHN</p>			
IDENTIFICATION NO.	69901-123456789		
GROUP NO.	69901	BC PLAN CODE 121	BS PLAN CODE 621
01-01-09			

To the Member: Member must call Blue Care Connection (BCC) to pre-certify one business day in advance for inpatient hospital stays, skilled nursing facility admissions, home health care and private duty nursing services or within two business days for emergency or maternity admissions.
Healthy Expectations: Members must call BCC within the first trimester of pregnancy to enroll into the mandatory program.
BlueCare Connection (BCC): 1-800-572-3089
Mental Health/Chemical Dependency 1-800-851-7498: Member must call prior to hospital admission or within two days of emergency admission.
FAILURE TO CONTACT EITHER BCC OR MENTAL HEALTH/CHEMICAL DEPENDENCY UNIT MAY REDUCE YOUR AVAILABLE BENEFITS
Provider Locator: To find a PPO Provider in your service area or when traveling, please call: **1-800-810-BLUE (2583)** or use the provider finder at www.bcbsil.com
To Hospital/Physician: Please file all claims with your local Blue Cross and Blue Shield Plan.
To the Member: If a provider does not submit your claim on your behalf, please contact your Customer Service Unit for assistance.
Customer Service: 1-800-409-9462
BlueAccess for Members at: www.bcbsil.com for claims and eligibility information.
24/7 Nurseline: 1-800-299-0274
Pharmacy Program: 1-800-423-1973
 Blue Cross and BlueShield of Illinois, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment service only and does not assume any financial risk or obligation with respect to claims.

Medicare supplemental group numbers for individual subscribers are:

- 69954-69999
- 32930-32937

Medicare supplemental alpha prefixes are:

- XOS Individual
- XON Group
- XOT Some older cards may have the XOT alpha prefix

If the employer group retains coverage for their retirees, the supplemental coverage ID card is often the same as a regular BCBSIL ID card.

Medicare Select

The Medicare Select product is a Medicare Supplemental benefit plan that is the same as BCBSIL's standard Medicare Supplement benefit plans with one exception: The Part A inpatient hospital deductible normally covered under the standard supplemental plans will be waived when the member is admitted into a Medicare Select participating hospital. Medicare Select products are only available to individuals living within a 30-mile radius of a Medicare Select participating hospital. Even though a member must live within a 30-mile radius of a Medicare Select participating hospital, they may use any Medicare Select network hospital. Medicare Select members are identified by group numbers 69901-69952.

If the member is admitted to a non-network Medicare Select hospital, payment of the Part A deductible will be the member's responsibility, **with the following exceptions:**

- Emergency admission
- If required covered services are not available through a Medicare Select network hospital

Medicare Select Network Hospitals




Hospital	City	Hospital	City
Adventist Bolingbrook	Bolingbrook	Proctor Hospital	Peoria
Adventist Glenoaks Hospital	Glendale Heights	Provena Covenant Med Ctr Urbana	Urbana
Adventist Hinsdale Hospital	Hinsdale	Provena Mercy Center Hlth Care	Aurora
Adventist Lagrange Memorial Hospital	Lagrange	Provena Saint Joseph Medical Ctr	Joliet
Advocate Christ Hospital	Oak Lawn	Provena St Joseph Hosp Elgin	Elgin
Advocate Good Shepherd	Barrington	Provena St Marys Hospital	Kankakee
Advocate Illinois Masonic Medical Center	Chicago	Provena United Samaritan Med Ctr	Danville
Advocate Good Samaritan Hospital	Downers Grove	Provident Hospital of Cook County	Chicago
Advocate Lutheran General Hospital	Park Ridge	Rehabilitation Inst of Chicago	Chicago
Advocate South Suburban Hospital	Hazel Crest	Resurrection Hospital	Chicago
Advocate Trinity Hospital	Chicago	Riveredge Hospital	Forest Park
Alexian Brothers Behavioral Health	Hoffman Estates	Riverside Medical Center	Kankakee
Alexian Brothers Medical Center	Elk Grove Village	RML Chicago	Chicago
Aurora Chicago Lakeshore Hosp	Chicago	RML Specialty Hospital	Hinsdale
Decatur Memorial Hospital	Decatur	Roseland Community Hospital	Chicago
Dr John Warner Hospital	Clinton	Rush Copley Medical Center	Aurora
Edward Hospital	Naperville	Rush Oak Park Hospital	Oak Park
Gottlieb Memorial Hospital	Melrose Park	Schwab Rehabilitation Hospital	Chicago
Graham Hospital Association	Canton	Silver Cross Hospital	New Lenox
Holy Cross Hospital	Chicago	Skokie Hospital	Skokie
Holy Family Medical Center	Des Plaines	St Alexius Hospital	Hoffman Estates
Illini Hospital	Silvis	St Anthony Hospital	Chicago
Ingalls Memorial Hospital	Harvey	St Anthonys Hospital	Rockford
Jackson Park Hospital	Chicago	St Elizabeth Hospital Chicago	Chicago
John H. Stroger Hospital (Cook County Hosp)	Chicago	St Francis Hospital	Evanston
Kenneth Hall Regional Hospital	E. St. Louis	St Francis Hospital Medical Center	Peoria
Little Company of Mary Hospital	Evergreen Park	St James Hospital	Pontiac
Louis A Weiss Memorial Hospital	Chicago	St James Hospital - Chicago Heights Campus	Chicago Heights
Loyola University Medical Center	Maywood	St James Hospital - Olympia Fields Campus	Olympia Fields
MacNeal Memorial Hospital	Berwyn	St Johns Hospital	Springfield
Marianjoy Rehabilitation Hospital	Wheaton	St Joseph Health Center	Chicago
Memorial Medical Center	Springfield	St Mary of Nazareth Hospital	Chicago
Genesis Medical Center Aledo	Aledo	St Marys Hospital	Decatur
Mercy Hospital and Medical Center	Chicago	St Marys Hospital	Galesburg
Metrosouth Medical Center	Blue Island	Swedish Covenant Hospital	Chicago
Mount Sinai Hospital	Chicago	Taylorville Memorial Hospital	Taylorville
North Shore University - Glenbrook	Glenview	Thorek Hospital	Chicago
North Shore University - Highland Park	Highland Park	Touchette Regional Hospital	East St Louis
Northshore University - Evanston	Evanston	Trinity Medical Center	Moline
Northwest Community Hospital	Arlington Heights	Trinity Medical Center	Rock Island
Northwestern Memorial Hospital	Chicago	University of Chicago Medical Cen	Chicago
Norwegian American Hospital	Chicago	University of Illinois Hospital	Chicago
Oak Forest Hosp of Cook County	Oak Forest	Van Matre Health South Rehabilitation Hospital	Rockford
Our Lady of the Resurrection	Chicago	West Suburban Hospital	Oak Park
Palos Community Hospital	Palos Heights	Westlake Community Hospital	Melrose Park
Pekin Hospital	Pekin		

Revised 6/10/13

Medicare Select Identification Card

Group numbers for Medicare Select are:



- 69946-69950

		BlueCross BlueShield of Illinois	
<hr/>			
CONSUMER MARKETS			
Doe, Jane M.			
Identification No. 1 2 3 4 5 6 X O S 1 2 3 4 5 6 7 8 9			
Group No. 123456		BC PLAN CODE 121 BS PLAN CODE 621	
S MED SELECT-PLAN F		06/01/09	
SSN. 123-45-6789			
POLICY NO. CB-46.4			

Dental Insurance Card

The dental card is identified by a **D** prefix in the member's ID number. The type of coverage is marked **DENTS** (single coverage) or **DENTF** (family coverage).

The group number on the dental card may differ from the one on the member's health insurance card. The dental identification number should not be used when filing a claim for hospital or medical/surgical services.

	
BlueCross BlueShield of Illinois	
DOE, JOHN Q.	
IDENTIFICATION NO.	081234-D123456789
GROUP NO. 081234	BS Plan Code 621 BC Plan Code 121
Family CMM	DENTF 06-09-09

<p>TO THE DENTAL PROVIDER: All Dental providers should file claims in the usual manner to:</p> <p>PreDent Plan for Dental Care P.O. Box 2935 Chicago, Illinois 60690</p> <p>Customer Service: 1-800-367-6401</p>

BlueExtras Discount Program

Through the BlueExtras discount program, all BCBSIL group members are eligible to save money on value added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by the member's health benefits plan. There are no claims to file, no referrals and no pre-authorizations. And there is no additional fee to participate.

Prescription Program

Members save on many brand-name and generic prescription drugs purchased at participating pharmacies, including Osco Drug, Target, Kmart and hundreds more.

Dental Program

Members save on dental services, including exams, cleanings and X-rays.

Vision Program

The majority of the providers that participate in the Members First Vision Network are LensCrafters, Pearle Vision, Sears and JCPenney. Individual providers will be considered in areas where a network is needed.

Providers should note that presentation of this plastic card at your facility does not entitle the bearer to hospital or medical/surgical benefits.