BlueCross BlueShield of Illinois

Summary of Benefits

Blue Cross Medicare Advantage Select (HMO)SM

January 1, 2019 – December 31, 2019

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

Y0096_BEN_ILLISSB19_M

852261.0618

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-774-8592 (TTY: 711). We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.getblueil.com/mapd or call 1-877-774-8592 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2019.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. **In addition, you will pay a higher co-pay for services received by non-contracted providers.**

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2019 – December 31, 2019

	Blue Cross Medicare Advantage Select (HMO)[SM]
You have choices about how to get your Medicare benefits	• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Select (HMO)**).
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Select (HMO)** covers and what you pay. • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
Sections in this booklet	• Things to Know About **Blue Cross Medicare Advantage Select (HMO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits • Optional Benefits (you must pay an extra premium for these benefits)
	This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711). Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711).
Hours of Operation	Things to Know About **Blue Cross Medicare Advantage Select (HMO)** • From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time. • From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

	Blue Cross Medicare Advantage Select (HMO)[SM]
Phone Numbers and Website	If you are a member of this plan, call toll-free 1-877-774-8592 (TTY/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-877-608-2698 (TTY/TDD users should call 711). • Our website: www.getblueil.com/mapd
Who can join?	To join **Blue Cross Medicare Advantage Select (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Illinois: Cook, DuPage, Kane, and Will.
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Medicare Advantage Select (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (www.getblueil.com/mapd). Or, call us and we will send you a copy of the provider and pharmacy directories.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*. **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getblueil.com/mapd). Or, call us and we will send you a copy of the formulary.
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS

January 1, 2019 – December 31, 2019

	Blue Cross Medicare Advantage Select (HMO)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	$27.40 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.

	Blue Cross Medicare Advantage Select (HMO)[SM]
COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.	
INPATIENT CARE	
Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: • $225 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • You pay nothing per day for days 91 and beyond Out-of-network: • Not covered
Outpatient Surgery[1,2]	Ambulatory surgical center: • In-network: $300 copay • Out-of-network: Not covered Outpatient hospital: • In-network: $0-$300 copay • Out-of-network: Not covered
OUTPATIENT CARE AND SERVICES	
Doctor's Office Visits[1,2]	Primary care physician visit: • In-network: You pay nothing • Out-of-network: Not covered Specialist visit: • In-network: $50 copay • Out-of-network: Not covered

	Blue Cross Medicare Advantage Select (HMO)[SM]
Preventive Care[1,2]	• In-network: You pay nothing • Out-of-network: Not covered Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the total cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	$30 copay

	Blue Cross Medicare Advantage Select (HMO)[SM]
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $250 copay • Out-of-network: Not covered Diagnostic tests and procedures: • In-network: $0-$50 copay, depending on the service • Out-of-network: Not covered Lab services: • In-network: You pay nothing • Out-of-network: Not covered Outpatient X-rays: • In-network: $20 copay • Out-of-network: Not covered Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the total cost • Out-of-network: Not covered
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: • In-network: $35 copay • Out-of-network: Not covered Routine hearing exam: • In-network: $10 copay. You are covered for up to 1 every 3 years. Hearing aid fitting/evaluation: • In-network: $0 copay. You are covered for up to 1 every 3 years. Hearing aid: • In-network: $0 copay $1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every three years.

	Blue Cross Medicare Advantage Select (HMO)[SM]
Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $35 copay • Out-of-network: Not covered Preventive dental services: Cleaning: • In-network: $0 copay. You are covered for up to 2 every year. Dental X-ray(s): • In-network: $0 copay. You are covered for up to 1 every year. Oral exam: • In-network: $0 copay. You are covered for up to 2 every year. Comprehensive dental coverage: $1,000 annual max; 50% member pay for Basic Restorative services (ex. Cavaties, Non-surgical tooth extractions); 70% member pay for Endodontics, Major restorative services and prosthodontics (ex. Root canals, crowns and dentures) For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.

	Blue Cross Medicare Advantage Select (HMO)[SM]
Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: You pay nothing • Out-of-network: Not covered Routine eye exam: • In-network: $0 copay. You are covered for up to 1 every year. Contact lenses: • In-network: $0 copay Eyeglass frames: • In-network: $0 copay Eyeglasses lenses: • In-network: $35 copay. You are covered for up to 1 every 2 years. Eyeglasses or contact lenses after cataract surgery: • In-network: $35 copay • Out-of-network: Not covered Our plan pays up to $100 every two years for contact lenses, eyeglass lenses, and eyeglass frames from an in-network provider.
Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • In-network: $260 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 • Out-of-network: Not covered

	Blue Cross Medicare Advantage Select (HMO)[SM]
Mental Health Care[1,2] **(continued)**	Outpatient group therapy visit: • In-network: $30 copay • Out-of-network: Not covered Outpatient individual therapy visit: • In-network: $30 copay • Out-of-network: Not covered
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. In-network: • You pay nothing per day for days 1 through 10 • You pay nothing per day for days 11 through 20 • $172 copay per day for days 21 through 100 Out-of-network: • Not covered
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $30 copay, depending on the service • Out-of-network: Not covered Occupational therapy visit: • In-network: $35 copay • Out-of-network: Not covered Physical therapy and speech and language therapy visit: • In-network: $35 copay • Out-of-network: Not covered
Ambulance[1]	In-network: $300 copay Out-of-network: Not Covered
Transportation[1,2]	Up to 24 one-way trips every year to plan-approved locations

	Blue Cross Medicare Advantage Select (HMO)[SM]
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the total cost • Out-of-network: Not covered Other Part B drugs[1]: • In-network: 20% of the total cost • Out-of-network: Not covered
Acupuncture	Not covered
Chiropractic Care[1,2]	In-network: $20 copay Out-of-network: Not covered
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: • In-network: 0%-35% of the total cost, depending on the supply • Out-of-network: Not covered Diabetes self-management training: • In-network: You pay nothing • Out-of-network: Not covered Therapeutic shoes or inserts: • In-network: 35% of the total cost • Out-of-network: Not covered 0% cost sharing limited to diabetic test strips and meters obtained through the pharmacy for an Ascensia branded product (Contour Next One, Contour Next EZ and Contour Next). 35% cost sharing for plan approved non-preferred test strips and meters. All test strips will also be subject to a quantity limit of 204 per 30 days. 35% cost sharing for all other diabetic supplies in this category.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	In-network: 20% of the total cost Out-of-network: Not covered

	Blue Cross Medicare Advantage Select (HMO)[SM]
Wellness Programs	SilverSneakers®† Fitness Program • SilverSneakers® is the nation's leading exercise program designed exclusively for Medicare beneficiaries. Eligible members receive a standard fitness center membership where they can enjoy specialized low-impact • SilverSneakers classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. • Included
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: Not covered
Home Health Care[1,2]	• In-network: You pay nothing • Out-of-network: Not covered
Outpatient Substance Abuse[1,2]	Group therapy visit: • In-network: $75 copay • Out-of-network: Not covered Individual therapy visit: • In-network: $75 copay • Out-of-network: Not covered
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. $0 copay • In-network: $30 every three months over-the-counter (OTC) purchase allowance.

† SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

	Blue Cross Medicare Advantage Select (HMO)[SM]
Prosthetic Devices ***(braces, artificial limbs, etc.)***[1]	Prosthetic devices: • In-network: 20% of the total cost • Out-of-network: Not covered Related medical supplies: • In-network: 20% of the total cost • Out-of-network: Not covered
Renal Dialysis[1,2]	• In-network: 20% of the total cost • Out-of-network: Not covered
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

	Blue Cross Medicare Advantage Select (HMO)SM		
PRESCRIPTION DRUG BENEFITS			
Initial Coverage	You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.		
	Standard Retail Cost-Sharing		
	Tier	**One-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$5 copay	$15 copay
	Tier 2 (Generic)	$18 copay	$54 copay
	Tier 3 (Preferred Brand)	$47 copay	$141 copay
	Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay
	Tier 5 (Specialty Tier)	31% of the total cost	31% of the total cost
	Preferred Retail Cost-Sharing		
	Tier	**One-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$0 copay	$0 copay
	Tier 2 (Generic)	$13 copay	$39 copay
	Tier 3 (Preferred Brand)	$42 copay	$126 copay
	Tier 4 (Non-Preferred Brand)	$95 copay	$285 copay
	Tier 5 (Specialty Tier)	31% of the total cost	31% of the total cost

	Blue Cross Medicare Advantage Select (HMO)[SM]	
Initial Coverage (continued)	**Standard Mail Order Cost-Sharing**	
	Tier	**Three-month supply**
	Tier 1 (Preferred Generic)	$15 copay
	Tier 2 (Generic)	$54 copay
	Tier 3 (Preferred Brand)	$141 copay
	Tier 4 (Non-Preferred Brand)	$300 copay
	Tier 5 (Specialty Tier)	31% of the total cost
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.	
	Preferred Mail Order Cost-Sharing	
	Tier	**Three-month supply**
	Tier 1 (Preferred Generic)	$0 copay
	Tier 2 (Generic)	$39 copay
	Tier 3 (Preferred Brand)	$126 copay
	Tier 4 (Non-Preferred Brand)	$285 copay
	Tier 5 (Specialty Tier)	31% of the total cost

	Blue Cross Medicare Advantage Select (HMO)SM
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% of the total cost, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-877-774-8592 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-877-774-8592 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-877-774-8592 (TTY: 711).

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-877-774-8592 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-774-8592 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-774-8592 (TTY: 711).

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-877-774-8592
(رقم هاتف الصم والبكم: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-877-774-8592 (телетайп: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-774-8592
(TTY: 711)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-877-774-8592
(TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-877-774-8592 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-774-8592 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-774-8592 (TTY: 711) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-774-8592 (ATS: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-774-8592 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-774-8592 (TTY: 711).

BlueCross BlueShield of Illinois

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-877-774-8592 (TTY:711) for more information.

HMO and HMO-POS plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.