BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

OUTLINE OF COVERAGE

BlueCare Direct Gold℠ 409 with Advocate

BlueCare Direct ℠

1. **READ YOUR POLICY CAREFULLY.** — This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. **BlueCare Direct - BlueCare Direct** provides to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services and Out-of-Hospital care, subject to any deductibles, Copayments or other limitations which may be set forth in your Policy. **To be covered under the Policy, the services you receive must be provided by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider, except in certain situations such as emergencies.** To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. The referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

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

BASIC PROVISIONS	**BlueCare Direct Gold 409 with Advocate**
	YOUR COST
Deductible Per individual, per calendar year	**$750***
Family Aggregate Deductible Per family, per calendar year	**$2,250***
Out-of-Pocket Expense Limitation* (does not apply to all services)	
Individual	**$9,100**
Family	**$18,200**
***NOTE**: Covered Services for sterilization procedures are covered at no cost to you when the services are ordered by your Primary Care Physician or Woman's Principal Health Care Provider.*	
PHYSICIAN BENEFITS	
Office Visit Copayment for the Treatment of Mental Illness	$20 per Visit
Copayment for Outpatient Physician office visits	$20 per Visit
Copayment for Outpatient Specialist office visits	$40 per Visit

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BASIC PROVISIONS	BlueCare Direct Gold 409 with Advocate
	YOUR COST
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or dollar maximum (to be implemented in the quantity and at the time required by applicable law or regulatory guidance): Evidence- based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	None
Copayment for Outpatient Occupational, Physical and Speech Therapy Treatments	$40 per Treatment
Copayment for Outpatient Surgery	$40 per Visit
Copayment for Telehealth and Telemedicine Services	
Outpatient Primary Care Physician office visits	$20 per Visit
Outpatient Specialist office visits	$40 per Visit
HOSPITAL BENEFITS	
Copayment for Inpatient Hospital Admissions	$750 per Day
Copayment for Inpatient Hospital Admission for the Treatment of Mental Illness	$750 per Day
Copayment for Skilled Nursing Facility	$500 per Day
Copayment for Outpatient Surgery	
Free Standing Facility	$300 per Visit, then 30% of the Eligible Charge
Hospital	$300 per Visit, then 30% of the Eligible Charge

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Copayment for Certain Diagnostic Tests: Computerized Tomography (CT Scan) Positron Emission Tomography (PET Scan) Magnetic Resonance Imaging (MRI):	
Free Standing Facility	$250 per Test
Hospital	$250 per Test
Copayment for Outpatient Laboratory Services:	
Free Standing Facility	$40 per Test
Hospital	$40 per Test
Copayment for Outpatient Diagnostic X-Ray Services:	
Free Standing Facility	$40 per Test
Hospital	$40 per Test
Copayment for Urgent Care	$40 per Visit
All Other Outpatient Covered Services	30% of the Eligible Charge
SUPPLEMENTAL BENEFITS	
Supplemental Benefits Blood and blood components; Outpatient Private Duty Nursing, medical and surgical dressings, supplies, casts and splints, oxygen and its administration, and naprapathic services.	30% of the Eligible Charge
EMERGENCY CARE SERVICES BENEFITS	
Copayment for Emergency Care Services (In-Area or Out-of-Area)	$1,000 per Visit, then 30% of Eligible Charge *(deductible waived if admitted to Hospital as an Inpatient immediately following emergency treatment)*
Emergency Ambulance Transportation	30% of the Eligible Charge
SUBSTANCE USE DISORDER BENEFITS	
Copayment for Inpatient Hospital Admission for Substance Use Disorder Treatment	$750 per Day
Copayment for Outpatient office visits for Substance Use Disorder Treatment	$20 per Visit
Copayment for Outpatient specialist office visits for Substance Use Disorder Treatment	$20 per Visit

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OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Please refer to the Outpatient Prescription Drug Program Section of the Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives. Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any deductible, Coinsurance Amount, and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptive drugs and products will be provided as shown below. If you or your provider request a brand name drug when a generic drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of brand name drug plus the difference between the allowable amount of the brand name drug and the allowable amount of the generic drug, except as otherwise provided in the policy. Any “differences” between the cost of the Generic Drug and the cost of the Brand Name Drug will apply to the deductible or out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall actual price of the drug.	
30-Day Supply Outpatient Prescription Drug Program	
Tier 1	10% of the Eligible Charge per prescription
Tier 2	15% of the Eligible Charge per prescription
Tier 3	20% of the Eligible Charge per prescription
Tier 4	30% of the Eligible Charge per prescription
Tier 5	40% of the Eligible Charge per prescription
Tier 6	50% of the Eligible Charge per prescription
90-Day Supply Outpatient Prescription Drug Program	
Tier 1	10% of the Eligible Charge per prescription
Tier 2	15% of the Eligible Charge per prescription
Tier 3	20% of the Eligible Charge per prescription
Tier 4	30% of the Eligible Charge per prescription
DEPENDENT LIMITING AGE	
Limiting Age for Dependent Children (regardless of presence or absence of child’s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors) (*In addition, enrolled unmarried children will be covered up to the age of 30 if they live within the service area of the Plan network for the Policy; and have served as an active or reserve member of any branch of the Armed Forces of the United States; and have received a release or discharge other than a dishonorable discharge.*)	26

PEDIATRIC VISION CARE SERVICES For Covered Persons Under Age 19	
Routine Exams (does not include professional services for contact lenses), Lenses, and Provider-Designated Frames and Contact Lenses	None
Low vision services and Laser vision correction Surgery (LASIK)	Traditional and custom LASIK Surgery will be available at a discount from Participating Physicians and affiliated laser centers.

HEARING AID BENEFITS for Individuals under age 19	
Benefit Period	24 months
Benefit payment level	30% of the Providers Charge, after your program deductible
Benefit Maximum	None Per Benefit Period
Number of Hearing Aids Available per ear each Benefit Period	One
HEARING AID BENEFITS for Individuals age 19 and over	
Benefit Period	24 months
Benefit Maximum	$2,500 per ear, per Benefit Period
Benefit payment level	30% of the Providers Charge, after your program deductible

*The program deductible and Out-of-Pocket Expense Limitation amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

GUARANTEED RENEWABILITY *

Coverage under this Policy will be terminated for nonpayment of premiums as described below. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called "Blue Cross and Blue Shield") may terminate or refuse to renew this Policy for any of the following reasons:

1. If every Policy that bears this Policy form number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
   b. You may convert to any other individual policy offered to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate this Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinues all health care coverage and does not renew all health insurance Policies it issues or delivers for issuance in the individual market in the state of Illinois. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield of Illinois' network service area.
5. Failure to pay your premium in accordance with the terms of the Policy. When you renew Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.
6. Other reasons described in this Policy.

* Blue Cross and Blue Shield will not terminate or refuse to renew this Policy because of the condition of your health.

Exclusions and Limitations

Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, HOSPITAL BENEFITS section and for Mental Illness (other than Serious Mental Illness) or for routine vision examinations, in the PHYSICIAN BENEFITS section of the Policy.

Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated, unless otherwise stated in this Policy.

Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 of the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

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

Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that Blue Cross and Blue Shield has provided benefits for the services or supplies rendered in connection with such injury.

Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature, except as specifically provided for in the Policy for a) Routine Patient Cost associated with Experimental/Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an Approved Clinical Trial program and b) applied

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

Special education therapy such as music therapy or recreational therapy, except as specifically provided for in the Policy.

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

Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

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

Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.

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

Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants, except as specifically stated in the Policy.

Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of disease or injury.

Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in the Policy.

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

Hypnotism.

Inpatient Private Duty Nursing Service.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically stated in the Policy.

behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service. Long Term Care Services.

Respite Care Services, except as specifically mentioned under the Hospice Care Benefits.

Maintenance Care.

Self-management training, education and medical nutrition therapy, except as specifically stated in the Policy.

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

Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in the Policy.

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

Services or supplies rendered for human organ or tissue transplants except as specifically provided for in the Policy.

Wigs (also referred to as cranial prostheses) unless otherwise specified in the Policy.

Services or supplies rendered for infertility treatment, except as specifically provided for in the Policy. Eyeglasses, contact lenses which are not medically necessary and/or hearing aids, except as specifically provided for in the Policy.

Acupuncture.

Reversal of vasectomies.

Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.

Any related services to a non-covered service except for routine patient care for participants in an Approved Clinical Trial.

Any service and/or supplies provided to you outside the United States, unless they are received for an Emergency Condition, notwithstanding any provision in the Policy to the contrary.

Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in the Policy.

Benefits will not be provided for any self-administered drugs dispensed by a Physician.

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