BlueCross BlueShield of Illinois

MEDICAL SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period		
Individual	$1,500	$2,500
Family (non-embedded)	$3,000	$5,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Non-embedded family deductible**: Any number of covered family members may help to satisfy the family deductible before this ***Plan*** begins to pay for ***covered expenses*** that are subject to the deductible.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, ***copays***, and prescription drug cost-share)		
Individual	$5,000	$10,000
Family (embedded)	$10,000	$19,600
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount***		
Standard *coinsurance* paid by the *Plan*	80%	60%

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	80% after deductible	60% after deductible
	Maximum: 20 visits per benefit period	
Allergy Services Allergy testing, injections and serum Specialist	$40 ***copay*** deductible waived	60% after deductible
Ambulance (Land/Air)	80% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	80% after deductible	60% after deductible
Birthing Center	80% after deductible	60% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Chemotherapy	$40 ***copay*** deductible waived	60% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	$40 ***copay*** deductible waived	60% after deductible
	Maximum: 20 visits per benefit period	
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	80% after deductible	60% after deductible
Diagnostic Services – Minor Laboratory services (includes independent labs)	80% after deductible	60% after deductible
X-ray services (includes freestanding facilities)	80% after deductible	60% after deductible
Dialysis Therapy or Treatment	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Emergency Room Services ***Emergency Medical Condition* Care** ***Facility*** (***copay*** waived if admitted)	$500 ***copay*** deductible waived	***preferred provider*** benefit applies
Physician	80% deductible waived	***preferred provider*** benefit applies

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Room Services (Cont'd)		
Non-***Emergency Medical Condition*** **Care**		
Facility (***copay*** waived if admitted)	$500 ***copay*** deductible waived	$500 ***copay*** deductible waived
Physician	80% deductible waived	60% deductible waived
	Non-Emergency use of the ER, without a later admission for reasons that do not meet the definition of emergency under the Affordable Care Act will be assessed a $500 penalty and the penalty should not apply towards the deductible or out-of-pocket maximums.	
Extended Care Facility	80% after deductible	60% after deductible
	Maximum: 90 days per benefit period	
Hearing Aids		
Prescription hearing aids and related services	80% after deductible	60% after deductible
	Maximum: One hearing aid per 3 calendar years up to maximum of $5,000.	
Home Health Care		
Home health care visits	80% after deductible	60% after deductible
	Maximum: 120 visits per benefit period combined with private duty nursing	
Home health care supplies & services	80% after deductible	60% after deductible
IV therapy	80% after deductible	60% after deductible
Hospice Care		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Hospital – Inpatient		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
Infusion Therapy	80% after deductible	60% after deductible
MDLive **Telemedicine**		
Medical	$25 ***copay*** deductible waived	Not Covered
Behavioral Health	$25 ***copay*** deductible waived	Not Covered
Occupational Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible
Surgery		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Lab		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
X-ray		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Other services		
Primary care physician	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Orthotics	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	60% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	60% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	80% after deductible	60% after deductible
Private Duty Nursing		
Inpatient	Not Covered	Not Covered
Outpatient	80% after deductible	60% after deductible
	Maximum: 120 visits per benefit period combined with Home Health Care.	
Prostheses	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Retail Clinic Visits	$25 ***copay*** deductible waived	60% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies 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). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	60% after deductible
Routine Prostate Examinations	100% deductible waived	60% after deductible

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Speech Therapy	80% after deductible	60% after deductible
	Maximum: 90 visits combined for physical, occupational, speech, pulmonary and cognitive therapy per benefit period. Benefits for Autism Spectrum Disorder(s) will not apply towards and are not subject to any physical, occupational or speech therapy visits maximums.	
Telemedicine Services		
Primary care physician (includes outpatient visits for ***mental health disorders/substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$40 ***copay*** deductible waived	60% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Transplants (Organ or Tissue)		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Transportation and lodging	80% after deductible	60% after deductible
	Maximum: Transportation $10,000 per transplant. Recipient must reside more than 50 miles from transplant facility.	
Urgent Care Center		
Visit	80% after deductible	60% after deductible
All other services	80% after deductible	60% after deductible
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services	Based on service provided	Based on service provided
Surgical treatment	Based on service provided	Based on service provided
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy, radiation therapy, or alopecia)*	80% after deductible	60% after deductible
	Maximum: $1,000 maximum every 24 months.	

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MEDICAL BENEFITS COPAY ADVANTAGE	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	60% after deductible
All Other C*overed Expenses*	80% after deductible	60% after deductible

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PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: January 1, 2024 – December 31, 2024

PRESCRIPTION DRUG PROGRAM BENEFITS – COPAY ADVANTAGE	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
Participating Pharmacy Out-of-Pocket Expense Limit (per benefit period) is the same as and is combined with the Medical Preferred Provider Out-of-Pocket Expense Limit.		
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (30-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Applicable
Generic	20% minimum $10 up to maximum of $40	
Formulary Brand Name	20% minimum $40 up to maximum of $75	
Non-Formulary Brand Name	20% minimum $50 up to maximum of $125	
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Covered
Generic	20% minimum $25 up to maximum of $100	
Formulary Brand Name	20% minimum $100 up to maximum of $185	
Non-Formulary Brand Name	20% minimum $140 up to maximum of $315	
Specialty Drugs (30-day supply)	$150 ***copay***	Not Covered

If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent.

Maintenance medication under 90-day My Way: 90-day supply at Retail or Mail Order.

For ***nonparticipating pharmacy*** the ***covered person*** is responsible for 25% of the eligible amount after ***coinsurance***.