

State of Illinois Benchmark Plan  
Blue Cross Blue Shield of Illinois BlueAdvantage Entrepreneur

Benefit	BCBSIL Blue Advantage	Conditions for Coverage or Limitations
<b>1. Ambulatory Patient Services</b>		
Primary Care to treat illness/injury	Yes	
Specialist visits	Yes	
Pediatrician office visit	Yes	
Urgent care facility	Yes	
Surgery facility – outpatient procedure at an ambulatory surgical center	Yes	
Surgery – Assistant Surgeon	Yes	
Additional Surgical Opinion	Yes	Following a recommendation for elective surgery. Covered at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation
Blood and blood components	Yes	Covered at 80% instead of 90% This includes, but is not limited to, all clotting factors necessary for the treatment of blood disorders, such as hemophilia.
Dental Ancillary Services	Yes	Only covered in the event of an accident.
Acupuncture	No	
Chemotherapy	Yes	Both in-patient and out-patient services are eligible based on medical necessity.
Radiation Therapy	Yes	Both in-patient and out-patient services are eligible based on medical necessity.
Biological Drugs	Yes	
Oxygen and its administration	Yes	Covered at 80% instead of 90%
Outpatient end stage renal disease treatment	Yes	Both in-patient and out-patient services are eligible based on medical necessity.
Infertility treatment services	Yes	Mandated
Sterilization	Yes	
Home health care	Yes	<p>Medical Services Advisory (MSA) must review for services received in a Coordinated Home Care Program. The covered individual must be homebound (unable to leave home without assistance and requiring supportive devices or special transportation) and they must require Skilled Nursing Service on an intermittent basis under the direction of the physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, hospital laboratories, and necessary medical supplies.</p> <p>The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).</p>

Outpatient Contraceptive Services	Yes	Mandated. Benefits will be provided for prescription contraceptive devices, injections, implants and outpatient contraceptive services.  Outpatient contraceptive services includes consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.
Basic dental care – Adult	No	
Major dental care – Adult	No	
Dental care required for the <u>direct treatment of a medical condition</u>	No	Could theoretically be covered if specifically and directly related to the medical condition, but this is rare.  Cleft palate is covered under the exception to the Cosmetic Exclusion for correction of a congenital deformity. Conditions that are an indirect cause of dental problems, e.g., radiation therapy that causes deterioration of teeth resulting in needing dental care would not be covered. If dental work was needed to treat cancer itself it would be covered (this would be an extremely rare case).
Orthodontia – Adult	No	
Dental care due to accident or injury – Adult	Yes	Coverage only for sound natural teeth
Routine Foot care	No	Routine foot care is covered for persons with diabetes
Routine Care During Cancer Clinical Trials	Yes	Mandated
<b>2. Emergency Services</b>		
Emergency services – facility	Yes	
Emergency services – physician	Yes	
Emergency medical care resulting from a criminal sexual assault or abuse	Yes	Covered at 100% with no cost-sharing
Ambulance service – ground and air	Yes	Covered at 80% instead of 90%. Not provided for long distance trips because it is more convenient than other transportation.
<b>3. Hospitalization</b>		
Inpatient medical and surgical care	Yes	Requires Medical Services Advisory (MSA) review.
Surgery – assistant surgeon	Yes	
Human Organ Transplants	Yes	Benefits for certain human organ transplants are the same as the benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:  <ul style="list-style-type: none"> <li>– If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.</li> <li>– If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.</li> <li>– If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the</li> </ul>

		<p>recipient.</p> <p>Benefits will be provided for:</p> <ul style="list-style-type: none"> <li>— Inpatient and Outpatient Covered Services related to the transplant Surgery.</li> <li>— The evaluation, preparation and delivery of the donor organ.</li> <li>— The removal of the organ from the donor.</li> <li>— The transportation of the donor organ to the location of the transplant Surgery.</li> </ul> <p>Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at a BCBS approved Human Organ Transplant Coverage Program.</p> <p>Benefits for transportation and lodging are limited to a maximum of \$10,000 per transplant. Max for lodging per person, per day, is \$50.</p> <p>Benefits will NOT be provided for:</p> <ul style="list-style-type: none"> <li>— Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery.</li> <li>— Travel time and related expenses required by a provider.</li> <li>— Drugs which do not have approval of the Food and Drug Administration.</li> <li>— Storage fees</li> <li>— Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.</li> <li>— Meals</li> </ul>
Bariatric surgery	Yes	If medically necessary.
Anesthesia	Yes	
Oral surgery/TMJ services and devices	Yes	<p>Limited to:</p> <ol style="list-style-type: none"> <li>1. Surgical removal of complete bony impacted teeth.</li> <li>2. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.</li> <li>3. Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.</li> <li>4. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.</li> </ol>
Breast reconstruction after mastectomy	Yes	Mandated
Reconstructive surgery (other than related to mastectomy)	Yes	Limited to correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
Blood transfusions	Yes	
Hospice	Yes	<p>Coverage includes:</p> <ol style="list-style-type: none"> <li>1. Coordinated Home Care</li> <li>2. Medical supplies and dressings</li> <li>3. Medication</li> </ol>

		<p>4. Nursing Services – Skilled and non-Skilled  5. Occupational Therapy  6. Pain management services  7. Physical Therapy  8. Physician visits  9. Social and spiritual services  10. Respite Care Service</p> <p>The covered individual must have a terminal illness with a life expectancy of one year or less, as certified by the attending physician, and will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care.</p> <p>Exclusions:  1. Durable medical equipment (Charges for DME may be separated from the hospice benefit because DME is usually outsourced and billed accordingly; or the covered individual could possibly have different coverage amounts.)  2. Home delivered meals  3. Homemaker services  4. Traditional medical services provided for the direct care of the terminal illness, disease or condition  5. Transportation, including, but not limited to, Ambulance Transportation.</p> <p>Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.</p>
Respite care	Yes	Only available with hospice. Respite care to assist parents who have very ill children at home is not covered.
<b>4. Maternity and Newborn Care</b>		
Pre and post natal Care Services	Yes	
Delivery and inpatient maternity services	Yes	
Newborn child coverage	Yes	
<b>5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment</b>		
Mental/Behavioral Health/Substance Use Disorder - Inpatient Hospital	Yes	Requires Mental Health Unit Review. Exclusions include but may not be limited to: - Residential treatment centers are a general exclusion, except for SUD. - Subject to Admission Review and length of stay/service review for in-patient hospital admissions and/or review of outpatient services for the treatment of Mental Illness and Substance Abuse disorders.
Mental/Behavioral Health/ Substance Use Disorder – Outpatient	Yes	Includes, but is not limited to, psychological testing, neuropsychological testing, electroconvulsive therapy, intensive outpatient programs, partial hospitalization treatment programs, if it is a BCBS approved program.

Emergency MH/SUD Admission	Yes	Requires Mental Health Unit Review.
Partial Hospitalization	Yes	Requires Mental Health Unit Review. Must be rendered in a BC approved program.
Intensive Outpatient Treatment	Yes	Requires Mental Health Unit Review.
Residential Treatment Facility	Yes	Only for SUD disorders. Requires Mental Health Unit Review. Residential treatment centers for SUD disorders are covered with Mental Health Unit Review.
Detoxification	Yes	
Applied Behavior Analysis Based Therapies	Yes	Only for Autism Spectrum Disorder (mandated).
Electroconvulsive Therapy	Yes	Requires Mental Health Unit Review.
Other MH/SUD <u>Exclusions</u> (this is not an exhaustive list)		Exclusions include but may not be limited to: - Residential treatment centers, except for SUD - Subject to Admission Review and length of stay/service review for in-patient hospital admissions and/or review of outpatient services for the treatment of Mental Illness and Substance Abuse disorders. - Investigational treatments (see Other Exclusions below) - Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current <i>Diagnostic and Statistical Manual of Mental Disorders</i> published by the American Psychiatric Association. - Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. - Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. - Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.
<b>6. Prescription Drugs</b>		
Retail	Yes	
Mail Order	Yes	
Generic	Yes	
Brand	Yes	
Specialty	Yes	
Self-Injectibles medications	Yes	
Insulin/needles for diabetes	Yes	
Tobacco Cessation Drugs	Yes	
Fertility Drugs	Yes	Mandated
Biological Drugs	Yes	
Growth Hormone Therapy	Yes	

<b>7. Rehabilitative and Habilitative Services and Devices</b>		
Physical Therapy	Yes	A written plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by Multiple Sclerosis.
Preventive Physical Therapy for Multiple Sclerosis Patients	Yes	Mandated
Occupational Therapy	Yes	A written plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis
Speech Therapy	Yes	Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.
Pulmonary Rehabilitation Therapy	Yes	Covered based on medical necessity.
Cardiac Outpatient Rehab Services	Yes	Benefits will be provided only in Blue Cross and Blue Shield approved programs. Benefits are available if the covered individual has a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.  Benefits will be limited to a maximum of 36 outpatient treatment sessions within the six month period.
Inpatient Rehabilitation	Yes	
Autism Spectrum Disorder Coverage	Yes	Mandated
Habilitative Services	Yes	Mandated Benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met: 1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and 2. Treatment is administered by a licensed speech–language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and 3. Treatment must be Medically Necessary and therapeutic and not Investigational.
Chiropractic & Osteopathic Manipulation	Yes	\$1,000 per benefit period.
Massage Therapy	Yes	Massage therapy is eligible but not a massage therapist as a provider
Skilled Nursing facility Services	Yes	Requires Medical Services Advisory (MSA) review.
Durable Medical Equipment	Yes	Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or GB-10 HCSC 59 purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. Implants are covered separately. CPAPs are eligible based on medical necessity.

Prosthetics	Yes	<p>Benefits will be provided when:</p> <ol style="list-style-type: none"> <li>1. they are required to replace all or part of an organ or tissue of the human body, or</li> <li>2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.</li> </ol> <p>Benefits will also <b>include</b> adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition.</p> <p><b>Excludes</b> adjustments, repair and replacements of dental appliances other than intra-oral devices used in connection with the treatment of TMJ and Related Disorders, subject to specific limitations applicable to TMJ and Related Disorders, and replacement of cataract lenses when a prescription change is not required.</p>
Orthotics	Yes	<p>Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.</p> <p>Benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.</p>
Hearing Aids	No	Hearing aids are not covered for adults or children.
Cochlear Implants	Yes	Covers osseointegrated auditory implants.
<b>8. Laboratory Services</b>		
Lab Tests, X-ray services and Pathology – Inpatient	Yes	
Lab Tests, X-ray services and Pathology – Outpatient	Yes	
Imaging/Diagnostics (eg. MRI, CT scan, PET scan) - Inpatient	Yes	
Imaging/Diagnostics (eg. MRI, CT scan, PET scan) - Outpatient	Yes	
<b>9. Preventive and Wellness Services and Chronic Disease Management</b>		
Preventive Services	Yes	
Immunizations	Yes	
Bone Density Test	Yes	
Colorectal Cancer Screening	Yes	
Screening Mammography	Yes	
Preventive Foot Care	Yes	Only for persons with diabetes.
Adult vision exam	No	
Routine Adult hearing exam	No	
Allergy testing and treatment	Yes	

Nutrition	Yes	Includes diabetes education and habilitative services.  Excludes: Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate.  This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases for home use.
Diabetes Care Management	Yes	
Diabetes – Medically necessary equipment and supplies	Yes	Including Insulin pumps
Acupuncture	No	
Smoking Cessation Program	Yes	
Screening Pap Tests	Yes	
Prostate Cancer Screening	Yes	
<b>10. Pediatric Services, including Oral and Vision Care</b>		
Preventive Care – Physician Services	Yes	
Immunizations	Yes	
Treatment of Illness or Injury - Child	Yes	
Metabolic Formula and Low Protein Food for Inborn Errors of Metabolism	Yes	Only for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, as is mandated.  Physicians must issue a written order stating that the amino acid-based elemental formula is medically necessary.
Basic Dental Care – Child	No	
Preventive and Diagnostic Dental Care – Child	No	
Major Dental Care – Child	No	
Dental Accidents or Injury	Yes	Limited to treatment of sound natural teeth.
Dental care required for the <u>direct treatment of a medical condition</u>	No	Could theoretically be covered if specifically and directly related to the medical condition, but this is rare.
Orthodontia – Child	No	
Routine Eye Exam (child)	No	
Corrective Lenses (child)	No	
Hearing Aids – child	Yes	Not covered. Exclusion: Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.
Cochlear Implants – Child	Yes	Covers osseointegrated auditory implants
Hearing Exams - child	Yes	Only covered if related to medical diagnosis; covered for newborns with maternity care; paid same as any other services.

Other Exclusions:

- Services which are not, in the reasonable judgment of Blue Cross and Blue Shield, Medically Necessary.
- Services or supplies that are not specifically mentioned in the plan Certificate.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Routine physical examinations, unless otherwise specified in the plan Certificate.
- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in the plan Certificate.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.

- Immunizations, unless otherwise specified in this Certificate.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in the plan Certificate.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).
- Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.
- Hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants), or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- Residential Treatment Centers.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
- Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.