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# The HMOs of Blue Cross and Blue Shield of Illinois

## BlueAdvantage HMO

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300 East Randolph, Chicago, IL 60601 • Member Services: (800) 892-2803 • [www.bcbsil.com](http://www.bcbsil.com)

# 2010 Description of Coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions, including external independent reviews.
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at **(800) 892-2803**. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance or information, please contact the Illinois Department of Financial and Professional Regulation – Division of Insurance, Office of Consumer Health Insurance at **(877) 527-9431** or in writing to either of the following addresses:

**320 West Washington Street  
Springfield, IL 62767-0001**

**100 West Randolph Street, Suite 15-100  
Chicago, IL 60601-3251**

You may also contact the department online at <http://www.idfpr.com>.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)



**BlueCross BlueShield  
of Illinois**

Basics		Description of Coverage
<b>Your Doctor</b>		Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. A member's PCP and WPHCP must have a referral arrangement with each other. <b>All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).</b>
<b>Annual Deductible</b>		none
<b>Out-of-Pocket Maximum</b> (excludes drugs, vision, durable medical equipment and prosthetics)	Individual	\$1,500/calendar year
	Family	\$3,000/calendar year
<b>Lifetime Maximums</b>		none
<b>Pre-existing Condition Limitations</b>		none

In the Hospital	Description of Coverage	Health Care Plan Covers	You Pay
<b>Number of Days of Inpatient Care</b>	unlimited days	n/a	n/a
<b>Room &amp; Board</b>	private or semi-private room	100%*	\$250 / day 1 <sup>st</sup> 5 days
<b>Surgeon's Fees</b>	covered	100%*	\$0
<b>Doctor's Visits</b>	covered	100%*	\$0
<b>Medications</b>	covered	100%*	\$0
<b>Other Miscellaneous Charges</b>	see exclusions	100%*	\$0

Emergency Care			
<b>Emergency Services</b> (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part)	covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted.	100%	\$150
<b>Emergency Post-stabilization Services</b> covered if approved by PCP	primary care physician	100%*	\$30
	specialist	100%*	\$50

\* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

In the Doctor's Office		Description of Coverage	Health Care Plan Covers	You Pay
<b>Doctor's Office Visit</b> (copayment covers the visit and all covered services provided)		primary care physician	100%*	\$30
		specialist	100%*	\$50
<b>Routine Physical Exams</b>		covered	100%*	\$30
<b>Diagnostic Tests and X-rays</b>		covered	100%*	\$0
<b>Immunizations</b>		covered	100%*	\$0
<b>Allergy Treatment &amp; Testing</b>		covered	100%*	\$0
<b>Wellness Care</b>		covered	100%*	\$30
<b>Medical Services</b>				
<b>Outpatient Surgery</b>		hospital facility	100%*	\$0
		physician(s)	100%*	\$0
<b>Maternity Care</b>	Hospital Care	unlimited days	100%*	\$250 / day 1 <sup>st</sup> 5 days
	Physician Care	copay, if any, for 1 <sup>st</sup> visit only	100%*	\$30
<b>Infertility Services</b>		based on your group policy	100%* if covered	\$50
<b>Non-Serious Mental Health</b>	Outpatient	unlimited visits	100%*	\$50
	Inpatient	unlimited days	100%*	\$250 / day 1 <sup>st</sup> 5 days
<b>Substance Abuse/ Chemical Dependency</b>	Outpatient	unlimited visits	100%*	\$50
	Inpatient	unlimited days	100%*	\$250 / day 1 <sup>st</sup> 5 days
<b>Serious Mental Health</b>	Outpatient	unlimited visits	100%*	\$50
	Inpatient	unlimited days	100%*	\$250 / day 1 <sup>st</sup> 5 days
<b>Outpatient Rehabilitation Services</b> (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*	\$0
<b>Outpatient Speech Therapy</b> (for Pervasive Developmental Disorder only)		20 visits/CY	100%*	\$0

\* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

Other Services		Description of Coverage	Health Care Plan Covers	You Pay
<b>Durable Medical Equipment</b>		covered	100%*	\$0
<b>Prosthetic Devices</b>		covered	100%*	\$0
<b>Ambulance Service</b>		covered	100%*	\$0
<b>Hospice</b>		covered	100%*	\$0
<b>Coordinated Home Care</b> (excludes custodial care)		covered	100%*	\$0
<b>Prescription Drug –</b> up to 34 day supply per script	Generic	based on your group policy	100%*	\$10
	Formulary Brand	based on your group policy	100%*	\$40
	Non-formulary Brand	based on your group policy	100%*	\$60
	Self-injectable	based on your group policy	100%*	\$50
<b>Prescription Drug –</b> □ up to 90 day supply per script □ visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call Member Services for information on the 90 day pharmacy network	Generic	based on your group policy	100%*	\$20
	Formulary Brand	based on your group policy	100%*	\$80
	Non-formulary Brand	based on your group policy	100%*	\$120
	Self-injectable	based on your group policy	100%*	\$50
<b>Dental Services</b>		see limitations, pages 6-7	100%*	\$50
<b>Vision Care</b>	Exams	one every 12 months	100%*	\$30
	Eyewear	based on your group policy	0%	remainder after discount

\*HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

## Service Area

The HMO Illinois and BlueAdvantage HMO service areas include the Illinois counties of Boone, Christian, Cook, DeKalb, DuPage, Fulton, Greene, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, Lee, Livingston, Logan, Macoupin, Mason, McHenry, Menard, Monroe, Morgan, Ogle, Peoria, Sangamon, Stark, St. Clair, Stephenson, Tazewell, Whiteside, Williamson, Will, Winnebago and Lake county in Indiana. The HMO Illinois service area also includes Kenosha county in Wisconsin. *Please note: Some employer groups may have different service areas (see your employer for details) and the service area is subject to change.*

## Exclusions and Limitations

*To receive benefits, all care must be provided or coordinated by the member's Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP) or medical group/Independent Practice Association (IPA), except substance abuse/chemical dependency, vision care and hospital emergency care benefits, which are available at contracting providers without a PCP referral.*

Below is a summary list of exclusions and limitations. Your plan may have specific exclusions and limitations not included on this list – check *Your Health Care Benefit Program Certificate*.

### Exclusions

1. Services or supplies that are not specifically listed in *Your Health Care Benefit Program Certificate*.
2. Services or supplies that were not ordered by your primary care physician or Woman's Principal Health Care Provider, except as explained in the *Certificate*.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws.
5. 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 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, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
6. 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 the Plan has provided benefits for the services or supplies rendered in connection with such injury.
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.
8. Custodial care services.
9. Long Term Care services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions, which are not specifically the result of mental illness.
12. Special education therapy, such as music therapy or recreational therapy.
13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
15. 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.
16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.
19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Marriage counseling.
23. Hypnotism.
24. Inpatient and Outpatient Private-Duty Nursing Service.
25. Routine foot care, except for persons diagnosed with diabetes.
26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. 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.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the *Certificate*.
32. Hearing aids, except as stated in the *Certificate*.
33. Wigs (also referred to as cranial protheses).

## Limitations

In addition to the exclusions noted, the following limitations apply:

1. Benefits for oral surgery are limited to:
  - surgical removal of completely bony impacted teeth,
  - excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth,
  - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth,
  - 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 the facial bone,
  - external incision and drainage of cellulitis,
  - incision of accessory sinuses, salivary glands or ducts, and
  - reduction of, dislocation of or excision of the temporomandibular joints.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
  - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of “infertility”,
  - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or

- embryos from you, will be covered if you choose to use a surrogate,
- selected termination of an embryo in cases where the mother's life is not in danger,
  - cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
  - non-medical costs of an egg or sperm donor,
  - travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the plan,
  - infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
  - Infertility treatment rendered to your dependents under the age of 18.
7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.
  8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.
  9. Hospice benefits are only available for persons having a life expectancy of one year or less.
  10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.
  11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
    - recreational sunglasses
    - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
    - additional charges for tinted, photo-sensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
    - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations
  12. Durable Medical Equipment rental is covered up to the price of purchase.
  13. Mental health and chemical dependency treatment benefits may be limited – see your *Certificate*.
  14. Rehabilitation therapy benefits may be limited – see your *Certificate*.
  15. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

### **Pre-certification and Utilization Review**

All benefits are provided or coordinated by your PCP or WPHCP. Therefore, certification by the member is not required. Utilization review is conducted by your medical group/IPA, not by the HMO. To ensure fair and consistent decisions regarding medical care, the HMOs of Blue Cross and Blue Shield of Illinois require medical groups/IPAs to use nationally recognized utilization review criteria.

## Primary Care Physician (PCP) Selection

Each member must join a contracting medical group/IPA and select a PCP affiliated with that medical group/IPA to provide and coordinate care. Each female member may also choose an OB/GYN to be her Woman's Principal Health Care Provider (WPHCP). A member's PCP and WPHCP must have a referral arrangement with each other. A member has access to her WPHCP as often as needed without a PCP referral. Members may change PCPs/WPHCPs – refer to the Member Handbook or *Certificate* for instructions and exceptions. Listings of contracting providers are available in the printed HMO directory or online at [www.bcbsil.com](http://www.bcbsil.com).

## Access to Specialty Care

If clinically appropriate, your PCP or WPHCP will refer you to a specialist, usually within the same medical group as your PCP. If the member's preferred network specialist does not have a referral arrangement with your PCP/WPHCP, you may choose a new PCP/WPHCP with whom the specialist has such an arrangement. You can ask your PCP for a standing referral for conditions that require ongoing care from a specialist physician. Standing referrals may be made for a specified number of visits or a time period up to one year. Specialist copays may differ, depending on plan design.

## Out-of-Area Coverage

When you are out of state, urgent care and hospital emergency room services are available through a network of contracting Blue Cross and Blue Shield providers. When you are out of state for a minimum of 90 consecutive days, guest membership may be arranged in participating communities throughout the U.S. with the Guest Membership Coordinator.

## Financial Responsibility

You are responsible for copayments at time of service, as shown in the Description of Coverage. You are also responsible for payment for care not provided or coordinated by your PCP or WPHCP, except where otherwise noted. You should contact your employer's benefit administrator to confirm the level of your contribution to the premium.

## Continuity of Treatment (Transition of Care)

If a physician you are currently obtaining services from leaves the HMO network, you have the right to request transition of care benefits. To qualify for transition of care services, you must currently be undergoing a course of evaluation and/or medical treatment or be in the second or third trimester of pregnancy. The ongoing evaluation and/or medical treatment concerns a condition or disease that requires repeated health care services under a physician's treatment plan, with the potential for changes in a therapeutic regimen.

Transitional services may be authorized for up to 90 days from the date the physician terminated from the network. Authorization of services depends on the physician's agreement to comply with contractual requirements and submit a detailed treatment plan, including reimbursement from the HMO at specified rates and adherence to the HMO's quality assurance requirements, policies and procedures. All care must be transitioned to your new HMO PCP in the medical group/IPA after the transition period has ended. Coverage will be provided only for benefits outlined in your *Certificate*.

**Existing members:** Submit a written Transition of Care request *within 30 days* of receiving notice of the termination of the physician or medical group/IPA.

**New members:** Submit a written Transition of Care request *within 15 days* after your eligibility effective date. When submitting the transition of care form prior to your effective date, please include a copy of the signed application and/or confirmation of enrollment with the HMO.

### Submit the request to:

Blue Cross and Blue Shield of Illinois  
Customer Assistance Unit, Transition of Care  
300 East Randolph Street, 23rd Floor  
Chicago, IL 60601

Include the following information:

- Policyholder's name and work/home phone numbers
- Group and ID numbers

- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

You will be notified within 15 business days of the outcome of your Transition of Care request.

## Appeals Process

You can file an appeal by writing to the HMO or calling Member Services.

### Non-urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

### Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours – or no later than three calendar days – of the initial receipt of the clinical appeal request. You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your

PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

### Non-clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out-of-area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within five business days of receiving your request. If your appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the Committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.

ANY ENROLLEE NOT SATISFIED WITH THE PLAN'S RESOLUTION OF ANY CLINICAL APPEAL, APPEAL OR COMPLAINT MAY APPEAL THE FINAL PLAN DECISION TO THE DIVISION OF INSURANCE, CONSUMER SERVICES SECTION, THROUGH ONE OF THE FOLLOWING LOCATIONS:

- **100 West Randolph Street, Suite 15-100  
Chicago, IL 60601-3251**
- **320 West Washington Street,  
Springfield, IL 62767-0001**

You may also contact the Division of Insurance by phone or online at:

- **(877) 527-9431**
- **<http://www.idfpr.com>.**

**IMPORTANT:** External review determinations might not be appealable through the Division of Insurance.

Members have the right to request information on, the financial relationships between the HMO and any health care provider; the percentage of copayments, deductibles and total premiums spent on health care; and HMO administrative expenses.

**For any additional information concerning this Description of Coverage, call the HMO's toll-free number at (800) 892-2803.**

To receive a Description of Coverage specific to your benefits, call **(800) 892-2803** or return the enclosed pre-paid card.

**In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or *Certificate* shall control.**

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