Illinois EHB Benchmark Plan

Summary Information

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross Blue Shield of Illinois
Product Name	BlueAdvantage Entrepreneur PPO
Plan Name	BlueCross BlueShield of Illinois BlueAdvantage
Supplemented Categories (Supplementary Plan Type)	· Pediatric Oral (State CHIP) · Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Physician Office Visits	No							No
2	**Specialist Visit**	Covered	Specialty Provider Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Provider office Visit	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Hospital Services	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient or ambulatory surgical procedures	No							No

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6	**Hospice Services**	Covered	Hospice Care	No					Exclusions: 1. Durable medical equipment; 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. 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.	You must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Coverage includes: 1. Coordinated Home Care; 2. Medical supplies and dressings; 3. Medication; 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. Charges for DME may be separated from the hospice benefit because: - DME is usually outsourced and billed accordingly; or - You could possibly have different coverage amounts.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Service outside of plan service area	No							No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Covered	Infertility Treatment	Yes	6	Other other	6 Completed oocyte retrievals/ Lifetime		Benefits will not be provided for the following: 1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate. 2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were	Quantity limit is 4 with an additional 2 only following a live birth and under certain conditions. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.	Yes

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									carried to full term. 3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. 4. Non-medical costs of an egg or sperm donor. 5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield. 6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists. 7. Infertility treatment rendered to your dependents under age 18. In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.		
10	**Long-Term/Custodial Nursing Home Care**	Not Covered								Long Term Care and Custodial Care are excluded regardless of setting.	

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11	**Private-Duty Nursing**	Covered	Private Duty Nursing Service	No					Private Duty Nursing requires Medical Services Advisory (MSA) review including case management. Private Duty Nursing is excluded when you are an Inpatient. Custodial Care services are excluded. Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available nonprofessional personnel.		No
12	**Routine Eye Exam (Adult)**	Not Covered									
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Services	No							No

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14	**Home Health Care Services**	Covered	Coordinated Home Care Program	No					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.).	Needs Medical Services Advisory (MSA) review in order to maximize benefits for services received in a Coordinated Home Care Program. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your 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.	No
15	**Emergency Room Services**	Covered	Emergency Room Visit	No						Includes out-of-country emergencies.	No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance Transportation	No					Not covered under the hospice program. Not provided for long distance trips because it is more convenient than other transportation.		No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No						Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Hospital Services	No						Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	Yes
19	**Bariatric Surgery**	Covered	Bariatric Surgical Procedures	No							No
20	**Cosmetic Surgery**	Covered	Cosmetic Surgery	No					Covered only for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.		No
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility Services	No					No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.	Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.	No
22	**Prenatal and Postnatal Care**	Covered	Maternity Service	No						Includes lactation support.	No

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23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Maternity Service	No						Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental health and substance abuse services	No					Residential treatment centers are a general exclusion, except for Substance Use Disorders. Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: Residential treatment centers, except for Substance Use Disorders; Subject to Admission Review and length of stay/service review for Inpatient 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 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. 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). 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	No

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										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.	
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental health and substance abuse services	No					Residential treatment centers are a general exclusion, except for Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: Residential treatment centers, except for Substance Use Disorders; Subject to Admission Review and length of stay/service review for Inpatient 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 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social	No

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										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). 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.	
26	**Substance Abuse Disorder Outpatient**	Covered	Mental health and substance abuse	No					Residential treatment centers are a general exclusion, except for	Exclusions include but may not be limited to: Residential treatment	No

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	Services		services						Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	centers, except for Substance Use Disorder; Subject to Admission Review and length of stay/service review for Inpatient 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 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. 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). - 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	

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										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.	
27	**Substance Abuse Disorder Inpatient Services**	Covered	Mental health and substance abuse services	No					Residential treatment centers are a general exclusion, except for Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: - Residential treatment centers, except for Substance Use Disorders - Subject to Admission Review and length of stay/service review for Inpatient 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 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. 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	No

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										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). - 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.	
28	**Generic Drugs**	Covered	Generic Drugs	No							Yes
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No						Prescription tobacco cessation drugs are covered. Self-injectables are covered.	No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No							No

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31	**Specialty Drugs**	Covered	Specialty Drugs	No						Biologics are covered. Growth Hormone Therapy is covered.	No
32	**Outpatient Rehabilitation Services**	Covered	Rehabilitation Services	No							Yes
33	**Habilitation Services**	Covered	Habilitation Services	No					Benefit available only for Congenital, Genetic or Early Acquired Disorders diagnoses. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services are excluded.	Your 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.	No
34	**Chiropractic Care**	Covered	Chiropractic Manipulation	Yes	1000	Other other	Dollars per benefit period			Currently limited to $1,000 per benefit period. It is anticipated that this will be converted to a quantitative limit on visits.	No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					Implants are covered separately. Prosthetic Devices: Benefits will be provided for prosthetic devices, special appliances and surgical implants when: 1. they are required to replace all or part of an organ or tissue of the human body, or 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue. Benefits will also include 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 (excluding dental	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. Insulin pumps are covered. CPAPs are covered. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.	No

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									appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required). Orthotic Devices: 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. However, 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. Except as specifically mentioned in this Certificate, special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, and wigs (also referred to as cranial prostheses) are excluded.		
36	**Hearing Aids**	Covered	Hearing Aid						Not covered except for bone anchored hearing aids (osseointegrated auditory implants). Examinations for the prescription or fitting of hearing aids are excluded, except for one inpatient hearing screening for a newborn.		
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Diagnostic Test	No							No

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39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care	No					Immunizations are excluded except for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved.		No
40	**Routine Foot Care**	Covered	Routine Foot Care	No						Only covered for individuals with diabetes.	No
41	**Acupuncture**	Not Covered	Acupuncture								
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs								
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year				Supplemented using FEDVIP.	No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year)			Supplemented using FEDVIP.	No
45	**Dental Check-Up for Children**	Covered	Dental Check-Up for Children	Yes	3	Other other	One every 6 months and one every 12 months in a school setting			Limitations, including dollar limits, may apply. Supplemented using Illinois CHIP.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Additional Surgical Opinion	No					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.		No
2	**Other**	Covered	Human Organ Transplants	No					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. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate are excluded. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day. In addition, the following are excluded: Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery; travel time and related expenses required by a Provider; drugs which do not have approval of the Food and Drug Administration; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; meals.		No
3	**Outpatient Rehabilitation Services**	Covered	Cardiac Rehabilitation Services	Yes	36	Other other	treatments		Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have 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.		No
4	**Generic Drugs**	Covered	Outpatient Prescription Drug Program	No					The following are excluded from the Outpatient Prescription Drug Program but may be payable under other benefit sections of the Certificate: 1. Drugs which do not by law require a Prescription Order from a Provider or Health	These exclusions are generally applicable to all categories of drugs -- Generic, Preferred Brand, Non-preferred Brand and Specialty.	Yes

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									Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels,); and drugs or covered devices for which no valid Prescription Order is obtained. 2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies). 3. Administration or injection of any drugs. 4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative). 5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility. 6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law. 7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. 8. Drugs which are repackaged by a company other than the original manufacturer. 9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date. 10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. 11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous		

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									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. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. 12. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not medically Necessary, or otherwise improper. 13. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card. 14. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted. 15. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise. 16. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Section or that are determined to be highrisk compounds. 17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging. 18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by Blue Cross and Blue Shield. 19. Athletic performance enhancement drugs. 20. Allergy serum and allergy testing materials. 21. Some equivalent drugs manufactured under multiple brand names. Benefits may be limited to only one of the brand equivalents available. 22. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives. 23. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.		
5	**Generic Drugs**	Covered	Outpatient Prescription Drug Program	No					Prior authorization, step therapy, maximum day supply and/or quantity limitations may apply.	These exclusions are generally applicable to all categories of drugs -- Generic, Preferred Brand, Non-preferred Brand and Specialty.	No

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6	**Other**	Covered	Dental Accident Care	No					Dental services that are not required as a result of an accidental injury are excluded. Coverage is provided only for sound, natural teeth. If an injury or breakage is to a tooth with a previous weakness, such as one with a cavity or crown, it would not be considered a sound natural tooth and would not be covered.		No
7	**Other**	Covered	Naprapathic Service	Yes	1000	Other other	Dollars per benefit period			Currently limited to $1,000 per benefit period. It is anticipated that this will be converted to a quantitative limit on visits. Massage therapy is a covered service but massage therapists are not eligible providers.	No
8	**Other**	Covered	Autism Spectrum Disorders	No						Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is medically necessary, or, (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist: psychiatric care, including diagnostic services; psychological assessments and treatments; habilitative or rehabilitative treatments; therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.	No

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9	**Infertility Treatment**	Covered	Infertility Treatment	Yes	6	Other other	Completed oocyte retrievals		Benefits for treatments that include oocyte retrievals will be provided only when: 1) You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and 2) You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered. Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs. The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.		No
10	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply. Supplemented using Illinois CHIP.	Yes
11	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply. Supplemented using Illinois CHIP.	Yes
12	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply. Supplemented using Illinois CHIP.	No

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13	**Other**	Covered	Oral Surgery/TMJ	No						Benefits limited to: surgical removal of complete bony impacted teeth; excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and 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 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.	No
14	**Other**	Covered	Pulmonary Rehabilitation Therapy	No						Based on medical necessity.	No
15	**Other**	Covered	Nutrition	No					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. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.		No
16	**Other**	Covered	Blood and blood components	No						Covered at 80% instead of 90%. Includes clotting factors necessary for the treatment of blood disorders, such as hemophilia. Excludes blood derivatives not classified as drugs in the official formularies.	No
17	**Other**	Covered	Chemotherapy and Radiation Therapy	No						Both in-patient and out-patient as medically necessary.	No

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18	**Other**	Covered	Emergency medical care resulting from a criminal sexual assault or abuse	No						Covered at 100% with no cost sharing.	No
19	**Other**	Covered	End Stage Renal Disease	No						Both in-patient and out-patient as medically necessary.	No
20	**Other**	Covered	Physical Therapy	No					Covered when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis. Preventive physical therapy for Multiple Sclerosis patients is covered as mandated.		No
21	**Other**	Covered	Occupational Therapy	No					Covered when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis.		No
22	**Other**	Covered	Speech Therapy	No					Covered when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.		No
23	**Other**	Covered	Detoxification	No						Based on medical necessity for the particular addictive substance.	No
24	**Other**	Covered	Electroconvulsive Therapy	No							No
25	**Inpatient Physician and Surgical Services**	Covered	Assistant Surgeon	No						Follow Medicare guidelines as to whether reimbursement is available.	No
26	**Other**	Covered	Allergy Testing	No							No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	10
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	8
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	19
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	34
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	16
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	1
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	12
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4