BlueCross BlueShield of Illinois

2021 Small Group Plans

Blue Cross and Blue Shield of Illinois (BCBSIL) offers health care plans with the choice, flexibility and affordable options that growing companies want.

The 2021 Small Group Portfolio is available from January 1 until December 31, 2021. Employers can choose from a variety of plans that give members access to plenty of features and benefits. Here are some of the 2021 highlights.

Provider Telehealth Visits

Members have more access to health care through our new, in-network telehealth benefit. There's no need to put off care. They can see their own, in-network PCP or Specialist by phone, video or mobile app (if available) for the same copay as an in-office visit. If the group benefits already include 24/7 Virtual Visits, powered by MDLIVE®, in-network telehealth is in addition to those benefits.

$0 Preventive Drugs on Health Savings Account (HSA) Plans

Select HSA plans now feature a $0 copay for certain preventive drugs. This helps members stick to their treatment plans and better manage their health conditions. The plan chart on page 2 identifies plans with this added benefit.

Behavioral Health Program Services

- A Behavioral Health Member Services team that can help members find providers and answer questions about eligibility, benefits and more
- 24-hour access to a single point of contact for members and providers
- Information about inpatient and outpatient services (counseling, testing and more)
- Assistance with prior authorizations (when required) and case management services for all Behavioral Health levels of care and services

Virtual Visits: Care When and Where You Need It

Virtual Visits, powered by MDLIVE

Members now have access to Virtual Visits, 24 hours a day, seven days a week.

Virtual Visits provide a live consultation between a doctor and a member for many non-emergency medical issues and behavioral health needs.

Based on your location, consult with a board-certified doctor by phone at **888-680-8646**, online at **MDLIVE.com/bcbsil** or with the MDLIVE mobile app. Doctors are available on demand or by appointment.

Members may set up their profiles to include their member ID number, preferred pharmacy for e-prescriptions and credit card number for easy payment.

MDLIVE doctors and therapists can treat a variety of non-emergency conditions, including:

- Allergies
- Anxiety
- Asthma
- Cold/flu
- Depression
- Ear problems
- Nausea
- Pink Eye
- Rash
- Sinus Infections
- Skin rashes
- Stress Management
- Urinary symptoms
- And more!

Members have access to Virtual Visits at the same PCP office visit copay outlined in their group benefits.*

*Copays on certain HSA plans will vary.

MDLIVE.COM/BCBSIL

1-888-680-8646

(EXCLUDES HMO)

Powered by MDLIVE®

Blue Cross and Blue Shield of Illinois 2021 Small Group Plan Portfolio

				Calendar Year Deductibles		Medical and Rx Out-of-Pocket Expense		Coinsurance	Copayments				Per Occurrence Deductibles[3] Annual deductible and coinsurance will apply after the per occurrence deductible			Pharmacy Benefits		Pediatric Dental
Network	Plan Name	Plan ID	Range of HSA Contribution	Individual In/Out	Family In/Out	Individual OPX In/Out	Family OPX In/Out	Coinsurance In/Out	Primary Care and Virtual Visits Office Visits	Specialist Office Visits	Urgent Care	Advanced Imaging In (MRI, CT, & PET)	ER Visit[3] In/Out	Inpatient[3] In/Out	Outpatient[3] In/Out	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Pediatric Dental In/Out[5]
Participating Provider Organization℠ (Network Code: PPO)	Blue PPO Platinum℠ 119	P503PPO	NA	$250/ $500	$750/ $1,500	$1,250/ Unlimited	$3,750/ Unlimited	80%/50%	$30	$60	$60	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	70%/50%
	Blue PPO Platinum℠ 136	P5E1PPO	NA	$500/ $1,000	$1,500/ $3,000	$1,500/ Unlimited	$4,500/ Unlimited	90%/60%	$20	$40	$75	DC	$400	$200/$300	$150/$250	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue PPO Gold℠ 114	G534PPO	NA	$1,000/ $2,000	$3,000/ $6,000	$6,750/ Unlimited	$17,100/ Unlimited	80%/50%	$50	$70	$75	DC	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue PPO Gold℠ 107	G532PPO	NA	$1,500/ $3,000	$3,000/ $6,000	$5,500/ Unlimited	$11,000/ Unlimited	80%/50%	$40	$60	$75	DC	$400	$200/$300	$150/$250	$5/$15/$50/$100/$250/$350	$15/$25/$70/$120/$250/$350	70%/50%
	Blue PPO Gold℠ 116	G536PPO	NA	$2,000/ $4,000	$6,000/ $12,000	$5,000/ Unlimited	$15,000/ Unlimited	90%/60%	$45	$65	$75	DC	$500	$200/$300	$150/$250	$5/$15/$50/$100/$250/$350	$15/$25/$70/$120/$250/$350	70%/50%
	Blue PPO Gold℠ 102	G531PPO	NA	$2,500/ $5,000	$5,000/ $10,000	$5,000/ Unlimited	$10,000/ Unlimited	80%/50%	$20	$60	$75	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	70%/50%
	Blue PPO Gold℠ 123	G537PPO	NA	$2,600/ $5,200	$7,800/ $15,600	$2,600/ $5,200	$7,800/ $15,600	100%/100%	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	100%/ 100%
	Blue PPO Silver℠ 120	S532PPO	NA	$3,250/ $6,500	$9,750/ $19,500	$8,550/ Unlimited	$17,100/ Unlimited	60%/50%	$50	$70	$75	$500 copay[2]	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue PPO Gold℠ 101	G530PPO	NA	$3,750/ $7,500	$11,250/ $22,500	$3,750/ $7,500	$11,250/ $22,500	100%/100%	$35	$55	$75	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	100%/ 100%
	Blue PPO Silver℠ 135	S501PPO	NA	$4,500/ $9,000	$9,000/ $18,000	$7,900/ Unlimited	$15,800/ Unlimited	80%/50%	DC	DC	DC	DC	DC	DC	DC	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue PPO Silver℠ 104	S531PPO	NA	$4,700/ $9,400	$14,100/ $28,200	$8,550/ Unlimited	$17,100/ Unlimited	80%/50%	$45	$65	$75	DC	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue PPO Silver℠ 105	S535PPO	NA	$7,550 / $15,100	$15,100/ $30,200	$7,550/ $15,100	$15,100/ $30,200	100%/100%	$30	$50	$75	DC	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	100%/ 100%
	Blue PPO Gold℠ 113	G533PPO	$180-$280	$2,800 / $5,600	$8,400/ $16,800	$3,500/ Unlimited	$10,500/ Unlimited	90%/60%	DC	DC	DC	DC	DC	DC	DC	90%/90%/80%/70%/60%/50%[1,4]	80%/80%/70%/60%/60%/50%[1,4]	70%/50%
	Blue PPO Gold℠ 115	G535PPO	$475-$625	$2,800/ $5,600	$8,400/ $16,800	$5,000/ Unlimited	$13,800/ Unlimited	80%/50%	DC	DC	DC	DC	DC	DC	DC	90%/90%/80%/70%/60%/50%[4]	80%/80%/70%/60%/60%/50%[4]	70%/50%
	Blue PPO Silver℠ 133	S534PPO	$0-$115	$4,800/ $9,600	$13,800/ $27,600	$4,800/ $9,600	$13,800/ $27,600	100%/100%	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	100%/ 100%
	Blue PPO Silver℠ 200	S5J1PPO	$150-$400	$6,000/ $12,000	$12,000/ $24,000	$6,000/ $12,000	$12,000/ $24,000	100%/100%	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	100%/ 100%
	Blue PPO Bronze℠ 132	B536PPO	$0	$6,650/ $13,300	$13,800/ $27,600	$6,900/ Unlimited	$13,800/ Unlimited	80%/50%	DC	DC	DC	DC	$250	DC	$125/$125	90%/90%/80%/70%/60%/50%[4]	80%/80%/70%/60%/60%/50%[4]	70%/50%
	Blue PPO Bronze℠ 106	B535PPO	$0	$6,900/ $13,800	$13,800/ $27,600	$6,900/ $13,800	$13,800/ $27,600	100%/100%	DC	DC	DC	DC	$250	DC	$125/$125	100%[4,7]	100%[4,7]	100%/ 100%

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Footnotes

1. Select HDHP-HSA preventive prescription drugs will be covered with no member cost share.
2. Value is a flat copay. Deductible and coinsurance do not apply.
3. Per occurrence deductible applies unless otherwise indicated. Annual deductible and coinsurance will apply after the per occurrence deductible.
4. Prescription coinsurance applies after the medical deductible is met.
5. Pediatric Dental benefits are subject to the medical deductible before coverage begins. In-network benefits refer to services provided by BlueCare Dental PPO providers. You can find a provider at www.bcbsil.com/providers/dppo.htm.
6. Plan applies copays on the following services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery. See summary of benefits for a full list of copay amounts.
7. BCBSIL HMO and 100% cost sharing plans do not have the Preferred Pharmacy Network.
8. Urgent Care is covered at the Office Visit copay amount.

Blue Cross and Blue Shield of Illinois 2021 Small Group Plan Portfolio

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Network	Plan Name	Plan ID	Range of HSA Contribution	Individual In/Out	Family In/Out	Individual OPX In/Out	Family OPX In/Out	Coinsurance In/Out	Primary Care and Virtual Visits Office Visits	Specialist Office Visits	Urgent Care	Advanced Imaging In (MRI, CT, & PET)	ER Visit[3] In/Out	Inpatient[3] In/Out	Outpatient[3] In/Out	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Pediatric Dental In/Out[5]
Blue Choice Preferred PPO℠ (Network Code: BCE)	Blue Choice Preferred Platinum PPO℠ 119	P5E2BCE	NA	$250/ $500	$750/ $1,500	$1,250/ Unlimited	$3,750/ Unlimited	80%/50%	$30	$60	$60	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	70%/50%
	Blue Choice Preferred Platinum PPO℠ 136	P5E1BCE	NA	$500/ $1,000	$1,500/ $3,000	$1,500/ Unlimited	$4,500/ Unlimited	90%/60%	$20	$40	$75	DC	$400	$200/$300	$150/$250	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue Choice Preferred Gold PPO℠ 107	G532BCE	NA	$1,500/ $3,000	$3,000/ $6,000	$5,500/ Unlimited	$11,000/ Unlimited	80%/50%	$40	$60	$75	DC	$400	$200/$300	$150/$250	$5/$15/$50/$100/$250/$350	$15/$25/$70/$120/$250/$350	70%/50%
	Blue Choice Preferred Gold PPO℠ 102	G531BCE	NA	$2,500/ $5,000	$5,000/ $10,000	$5,000/ Unlimited	$10,000/ Unlimited	80%/50%	$20	$60	$75	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	70%/50%
	Blue Choice Preferred Silver PPO℠ 120	S532BCE	NA	$3,250/ $6,500	$9,750/ $19,500	$8,550/ Unlimited	$17,100/ Unlimited	60%/50%	$50	$70	$75	$500 copay[2]	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue Choice Preferred Gold PPO℠ 101	G530BCE	NA	$3,750/ $7,500	$11,250/ $22,500	$3,750/ $7,500	$11,250/ $22,500	100%/100%	$35	$55	$75	DC	$400	$200/$300	$150/$250	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	100%/ 100%
	Blue Choice Preferred Silver PPO℠ 135	S501BCE	NA	$4,500/ $9,000	$9,000/ $18,000	$7,900/ Unlimited	$15,800/ Unlimited	80%/50%	DC	DC	DC	DC	DC	DC	DC	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue Choice Preferred Silver PPO℠ 104	S531BCE	NA	$4,700/ $9,400	$14,100/ $28,200	$8,550/ Unlimited	$17,100/ Unlimited	80%/50%	$45	$65	$75	DC	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	70%/50%
	Blue Choice Preferred Silver PPO℠ 105	S535BCE	NA	$7,550/ $15,100	$15,100/ $30,200	$7,550/ $15,100	$15,100/ $30,200	100%/100%	$30	$50	$75	DC	$500	$250/$350	$200/$300	$0/$10/$50/$100/$150/$250	$10/$20/$70/$120/$150/$250	100%/ 100%
	Blue Choice Preferred Gold PPO℠ 113	G533BCE	$180-$280	$2,800/ $5,600	$8,400/ $16,800	$3,500/ Unlimited	$10,500/ Unlimited	90%/60%	DC	DC	DC	DC	DC	DC	DC	90%/90%/80%/70%/60%/50%[1,4]	80%/80%/70%/60%/60%/50%[1,4]	70%/50%
	Blue Choice Preferred Gold PPO℠ 115	G535BCE	$475-$625	$2,800/ $5,600	$8,400/ $16,800	$5,000/ Unlimited	$13,800/ Unlimited	80%/50%	DC	DC	DC	DC	DC	DC	DC	90%/90%/80%/70%/60%/50%[4]	80%/80%/70%/60%/60%/50%[4]	70%/50%
	Blue Choice Preferred Silver PPO℠ 133	S534BCE	$0-$115	$4,800/ $9,600	$13,800/ $27,600	$4,800/ $9,600	$13,800/ $27,600	100%/100%	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	100%/ 100%
	Blue Choice Preferred Silver PPO℠ 200	S5J1BCE	$150-$400	$6,000/ $12,000	$12,000/ $24,000	$6,000/ $12,000	$12,000/ $24,000	100%/100%	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	100%/ 100%
	Blue Choice Preferred Bronze PPO℠ 132	B536BCE	$0	$6,650/ $13,300	$13,800/ $27,600	$6,900/ Unlimited	$13,800/ Unlimited	80%/50%	DC	DC	DC	DC	$250	DC	$125/$125	90%/90%/80%/70%/60%/50%[4]	80%/80%/70%/60%/60%/50%[4]	70%/50%
	Blue Choice Preferred Bronze PPO℠ 106	B535BCE	$0	$6,900/ $13,800	$13,800/ $27,600	$6,900/ $13,800	$13,800/ $27,600	100%/100%	DC	DC	DC	DC	$250	DC	$125/$125	100%[4,7]	100%[4,7]	100%/ 100%
Blue Options℠ (Network Code: BCO)	Blue Options Gold PPO℠ 101	G506OPT	NA	$750 Tier 1/ $1,750 Tier 2 /$3,500 OON	$2,250 Tier 1/ $5,250 Tier 2 /$10,500 OON	$5,000 Tier 1 /$7,000 Tier 2 / Unlimited OON	$15,000 Tier 1 /$17,100 Tier 2 / Unlimited OON	80% Tier 1 /70% Tier 2 /50% OON	$40 Tier 1 /$60 Tier 2	$60 Tier 1 /$100 Tier 2	$75	DC	$600	$250 Tier 1 /$500 Tier 2 /$600 OON	$200 Tier 1 /$400 Tier 2 /$500 OON	$10/$20/$50/$100/$250/$350	$20/$30/$70/$120/$250/$350	70%/50%
	Blue Options Gold PPO℠ 106	G508OPT	NA	$1,500 Tier 1/ $3,250 Tier 2 /$6,500 OON	$4,500 Tier 1 /$9,750 Tier 2 /$19,500 OON	$4,100 Tier 1 /$6,100 Tier 2 / Unlimited OON	$12,300 Tier 1 /$17,100 Tier 2 / Unlimited OON	90% Tier 1 /70% Tier 2 /50% OON	$30 Tier 1 /$55 Tier 2	$45 Tier 1 /$95 Tier 2	$75	DC	$600	$250 Tier 1 /$500 Tier 2 /$600 OON	$200 Tier 1 /$400 Tier 2 /$500 OON	$10/$20/$50/$100/$250/$350	$20/$30/$70/$120/$250/$350	70%/50%
	Blue Options Gold PPO℠ 102	G507OPT	NA	$2,000 Tier 1 /$3,500 Tier 2 /$7,000 OON	$4,000 Tier 1 /$8,500 Tier 2 /$17,000 OON	$3,500 Tier 1 /$6,500 Tier 2 / Unlimited OON	$8,500 Tier 1 /$17,100 Tier 2 / Unlimited OON	90% Tier 1 /70% Tier 2 /50% OON	$35 Tier 1 /$60 Tier 2	$50 Tier 1 /$100 Tier 2	$75	DC	$400	$250 Tier 1 /$500 Tier 2 /$600 OON	$200 Tier 1 /$400 Tier 2 /$500 OON	$0/$10/$35/$75/$150/$250	$10/$20/$55/$95/$150/$250	70%/50%
	Blue Options Silver PPO℠ 104	S506OPT	NA	$4,850 Tier 1 /$5,850 Tier 2 /$11,700 OON	$14,550 Tier 1 /$17,100 Tier 2 /$34,200 OON	$6,850 Tier 1 /$8,550 Tier 2 / Unlimited OON	$17,100 Tier 1 /$17,100 Tier 2 / Unlimited OON	80% Tier 1 /60% Tier 2 /50% OON	$40 Tier 1 /$60 Tier 2	$60 Tier 1 /$100 Tier 2	$75	DC	$600	$250 Tier 1 /$500 Tier 2 /$600 OON	$200 Tier 1 /$400 Tier 2 /$500 OON	$10/$20/$50/$100/$250/$350	$20/$30/$70/$120/$250/$350	70%/50%
	Blue Options Silver PPO℠ 107	S507OPT	$0-$50	$4,000 Tier 1 /$4,750 Tier 2 /$9,500 OON	$12,000 Tier 1 /$13,800 Tier 2 /$27,600 OON	$4,000 Tier 1 /$6,900 Tier 2 / Unlimited OON	$12,000 Tier 1 /$13,800 Tier 2 / Unlimited OON	100% Tier 1 /80% Tier 2 /50% OON	DC	DC	DC	DC	DC	DC	DC	100%[4,7]	100%[4,7]	70%/50%

Blue Options: A tiered network offering that utilizes benefit design to encourage members to use a network of more cost-efficient providers, while still allowing access to the broad PPO network. Tier 1 refers to the benefit level when using the Blue Choice OPT PPO℠ network, Tier 2 refers to the benefit level when using the PPO network. OON refers to out of network.

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Footnotes

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Network	Plan Name	Plan ID	Range of HSA Contribution	Individual In/Out	Family In/Out	Individual OPX In/Out	Family OPX In/Out	Coinsurance In/Out	Primary Care Office Visits	Specialist Office Visits	Urgent Care	Advanced Imaging In (MRI, CT, & PET)	ER Visit[3] In/Out	Inpatient[3] In/Out	Outpatient[3] In/Out	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Pediatric Dental In/Out[5]
Blue Precision HMO℠ (Network Code: BAV)	Blue Precision Platinum HMO℠ 107	P506PSN[6]	NA	$0/NC	$0/NC	$1,500/NC	$4,500/NC	100%/NC	$10	$45	$45[8]	$250 copay[2]	$300 copay[2]	$150 copay[2] per visit/NC	$100 copay[2] per visit/NC	$0/$10/$50/$100/$150/$250[7]	$0/$10/$50/$100/$150/$250[7]	100%/NC
	Blue Precision Platinum HMO℠ 200	P5J1PSN[6]	NA	$0/NC	$0/NC	$2,000/NC	$6,000/NC	100%/NC	$20	$30	$30[8]	$250 copay[2]	$300 copay[2]	$150 copay[2] per visit/NC	$100 copay[2] per visit/NC	$0/$10/$50/$100/$150/$250[7]	$0/$10/$50/$100/$150/$250[7]	100%/NC
	Blue Precision Gold HMO℠ 201	G5J2PSN[6]	NA	$0/NC	$0/NC	$5,000/NC	$15,000/NC	100%/NC	$50	$70	$70[8]	$400 copay[2]	$500 copay[2]	$300 copay[2] per visit/NC	$250 copay[2] per visit/NC	$10/$20/$50/$100/$250/$350[7]	$10/$20/$50/$100/$250/$350[7]	100%/NC
	Blue Precision Platinum HMO℠ 110	P5E1PSN	NA	$1,000/NC	$3,000/NC	$3,000/NC	$9,000/NC	80%/NC	$25	$50	$50[8]	NC	$400	$200/NC	$150/NC	$0/$10/$50/$100/$150/$250[7]	$0/$10/$50/$100/$150/$250[7]	70%/NC
	Blue Precision Gold HMO℠ 101	G532PSN	NA	$2,500/NC	$7,500/NC	$8,550/NC	$17,100/NC	70%/NC	$55	$75	$75[8]	NC	$1,000	$400/NC	$350/NC	$10/$20/$50/$100/$250/$350[7]	$10/$20/$50/$100/$250/$350[7]	70%/NC
	Blue Precision Silver HMO℠ 106	S531PSN[6]	NA	$3,000/NC	$9,000/NC	$8,550/NC	$17,100/NC	80%/NC	$40	$60	$60[8]	$750 copay[2]	$1,000	$750 copay[2] per day/NC	$500/NC	$10/$20/$50/$100/$250/$350[7]	$10/$20/$50/$100/$250/$350[7]	70%/NC
	Blue Precision Silver HMO℠ 102	S530PSN[6]	NA	$7,000/NC	$17,100/NC	$7,900/NC	$17,100/NC	70%/NC	$55	$75	$75[8]	$400 copay[2]	$700	$300/NC	$250/NC	$0/$10/$50/$100/$150/$250[7]	$0/$10/$50/$100/$150/$250[7]	70%/NC

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1. Select HDHP-HSA preventive prescription drugs will be covered with no member cost share.
2. Value is a flat copay. Deductible and coinsurance do not apply.
3. Per occurrence deductible applies unless otherwise indicated. Annual deductible and coinsurance will apply after the per occurrence deductible.
4. Prescription coinsurance applies after the medical deductible is met.
5. Pediatric Dental benefits are subject to the medical deductible before coverage begins. In-network benefits refer to services provided by BlueCare Dental PPO providers. You can find a provider at www.bcbsil.com/providers/dppo.htm.
6. Plan applies copays on the following services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery. See summary of benefits for a full list of copay amounts.
7. BCBSIL HMO and 100% cost sharing plans do not have the Preferred Pharmacy Network.
8. Urgent Care is covered at the Office Visit copay amount.

Vision Insurance from Blue Cross and Blue Shield of Illinois

2021 HMO Pediatric Vision Care

Insured Benefit		
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Vision Care Services	**Member Cost In-Network**	**Out-of-Network Reimbursement***
Exam with Dilation as Necessary	$0 Copay	NA
Frames		
Frames Any available frame at provider location	$0 Copay on provider-designated frame; $150 allowance on non-provider designated frame, 20% off balance over $150	NA
Standard Plastic Lenses		
Single Vision	$0 Copay	NA
Bifocal	$0 Copay	NA
Trifocal	$0 Copay	NA
Lenticular	$0 Copay	NA
Standard Progressive	$0 Copay	NA
Lens Options		
UV Treatment	$0 Copay	NA
Tint (Fashion & Gradient & Glass-Grey)	$0 Copay	NA
Standard Plastic Scratch Coating	$0 Copay	NA
Standard Polycarbonate - Kids under 19	$0 Copay	NA
Glass	$0 Copay	NA
Photochromic/Transitions Plastic	$0 Copay	NA
Oversized	$0 Copay	NA
Contact Lenses (Contact lens allowance includes materials only)	**100% coverage for provider designated contact lenses**	
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	NA
Daily Wear/Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	NA
Conventional	1 pair from selection of provider designated contact lenses	NA
Medically Necessary	$0 Copay, Paid-in-Full	NA
Discounts on Services and Materials on Non-Insured Items		
Vision Care Services	**Member Cost In-Network**	**Out-of-Network Reimbursement***
Retinal Imaging Benefit	Up to $39	NA
Exam Options		
Standard Contact Lens Fit and Follow-Up	Up to $40	NA
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	NA
Standard Plastic Lenses		
Premium Progressive Lens Tier 1	$20 Copay	NA
Premium Progressive Lens Tier 2	$30 Copay	NA
Premium Progressive Lens Tier 3	$45 Copay	NA
Premium Progressive Lens Tier 4	$0 copay, 80% of charge less $120 Allowance	NA
Lens Options		
Standard Polycarbonate - Adults	$40	NA
Standard Anti-Reflective Coating	$45	NA
Premium Anti-Reflective Coating Tier 1	$57	NA
Premium Anti-Reflective Coating Tier 2	$68	NA
Premium Anti-Reflective Coating Tier 3	20% off Retail Price	NA
Polarized	20% off Retail Price	NA
Other Add-Ons	20% off Retail Price	NA
Other		
Laser Vision Correction	15% off Retail Price or 5% off promotional price	NA
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	NA

2021 Non-HMO Pediatric Vision Care

Insured Benefit		
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Vision Care Services	**Member Cost In-Network**	**Out-of-Network Reimbursement***
Exam with Dilation as Necessary	$0 Copay	$30
Frames		
Frames Any available frame at provider location	$0 Copay on provider-designated frame; $150 allowance on non-provider designated frame, 20% off balance over $150	$75
Standard Plastic Lenses		
Single Vision	$0 Copay	$25
Bifocal	$0 Copay	$40
Trifocal	$0 Copay	$55
Lenticular	$0 Copay	$55
Standard Progressive	$0 Copay	$55
Lens Options		
UV Treatment	$0 Copay	$12
Tint (Fashion & Gradient & Glass-Grey)	$0 Copay	$12
Standard Plastic Scratch Coating	$0 Copay	$12
Standard Polycarbonate - Kids under 19	$0 Copay	$32
Glass	$0 Copay	$12
Photochromic/Transitions Plastic	$0 Copay	$57
Oversized	$0 Copay	NA
Contact Lenses (Contact lens allowance includes materials only)	**100% coverage for provider designated contact lenses**	
Extended Wear Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	$150
Daily Wear/Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	$150
Conventional	1 pair from selection of provider designated contact lenses	$150
Medically Necessary	$0 Copay, Paid-in-Full	$210
Discounts on Services and Materials on Non-Insured Items		
Vision Care Services	**Member Cost In-Network**	**Out-of-Network Reimbursement***
Retinal Imaging Benefit	Up to $39	NA
Exam Options		
Standard Contact Lens Fit and Follow-Up	Up to $40	NA
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	NA
Standard Plastic Lenses		
Premium Progressive Lens Tier 1	$20 Copay	NA
Premium Progressive Lens Tier 2	$30 Copay	NA
Premium Progressive Lens Tier 3	$45 Copay	NA
Premium Progressive Lens Tier 4	$0 copay, 80% of charge less $120 Allowance	NA
Lens Options		
Standard Polycarbonate - Adults	$40	NA
Standard Anti-Reflective Coating	$45	NA
Premium Anti-Reflective Coating Tier 1	$57	NA
Premium Anti-Reflective Coating Tier 2	$68	NA
Premium Anti-Reflective Coating Tier 3	20% off Retail Price	NA
Polarized	20% off Retail Price	NA
Other Add-Ons	20% off Retail Price	NA
Other		
Laser Vision Correction	15% off Retail Price or 5% off promotional price	NA
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	NA

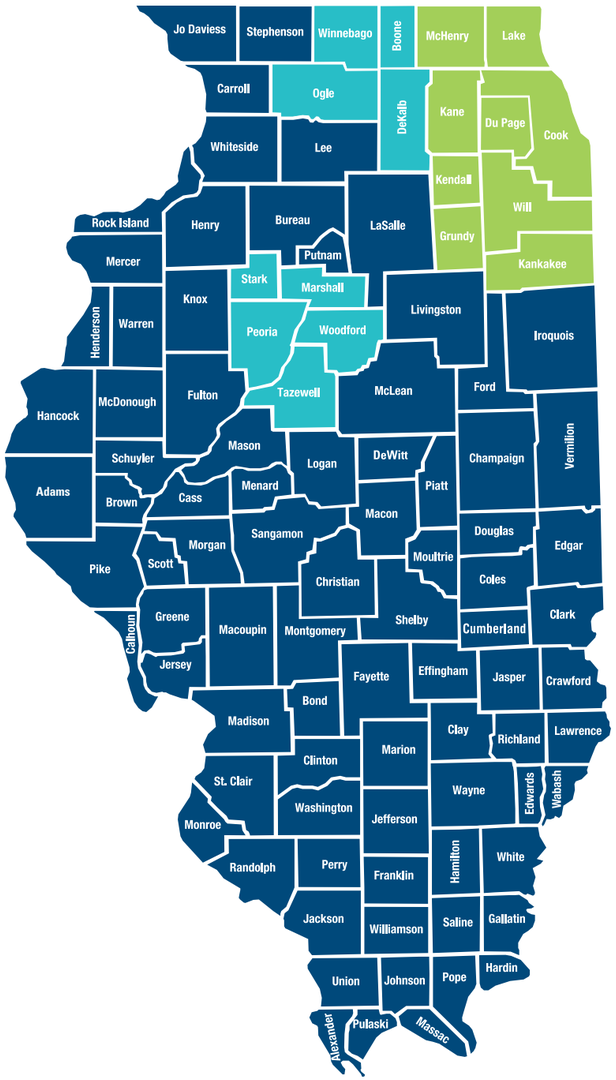
All plans utilize the EyeMed Select Network. Materials/services for a non-insured benefit are considered discounts and are subject to change at anytime without notice. Non-insured benefits must be paid to the provider in full.

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. This is a snapshot; the vision benefits and the Certificate of Insurance is the master.

EyeMed Vision Care, LLC, an independent company, provides customer service and network administration services for BCBSIL. BCBSIL has contracted with First American Administrators (FAA), an independent company, to provide claims administration. The relationship between BCBSIL, FAA, and EyeMed is that of independent contractors.

PLAN EXCLUSIONS: 1) Orthoptic or vision training; Aniseikonic spectacle lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care; 10) Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

2021 Illinois Small Group (1-50) Provider Networks by County



Network Names

- PPO and Blue Choice Preferred PPO
- PPO, Blue Choice Preferred PPO and Blue Precision HMO
- PPO, Blue Choice Preferred PPO, Blue Precision HMO and Blue Options

The map represents counties with provider access. Please refer to individual proposal or renewal exhibit to see if the client can select products utilizing these networks.

Help Members Get More Value from Their Pharmacy Benefits

Here are some ways members can get more value from their pharmacy benefits:

- Consider using generic drugs.
- Ask their doctor to check the prescription drug list when recommending prescription drug options. Drugs on the list are chosen for their safety, cost and how well they work.
- Use an in-network pharmacy.
- Go to **bcbsil.com** to check Blue Access for Members℠ (BAM℠) for online pharmacy resources, out-of-pocket prescription cost estimates, claims history and more.
- Ask doctors or pharmacists about the choices available and which drug is right for them.

Want more information?
Talk with your BCBSIL account representative today.

Prime Therapeutics LLC is a separate pharmacy benefit management company contracted by BCBSIL to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics. MyPrime.com is an online resource offered by Prime Therapeutics LLC.
A "preferred" or "participating" pharmacy has a contract with BCBSIL or BCBSIL's pharmacy benefit manager (Prime) to provide pharmacy services at a negotiated rate.
The terms "preferred" and "participating" should not be construed as a recommendation, referral or any other statement as to the ability or quality of such pharmacy.

Illinois Small Group Network Offerings Comparison

Plan Name	Participating Provider Organization	Blue Choice Preferred PPO	Blue Options	Blue Precision HMO
Network/Network Name	PPO	Blue Choice Preferred PPO (Network Code: BCE)	Tier 1 - Blue Options (Network Code: BCO) Tier 2 - PPO	Blue Precision HMO (Network Code: BAV)
Availability	1-50	1-50	1-50	1-50
Coverage	Statewide	Statewide	Tier 1 - Chicago Metro Tier 2 – Statewide	Chicago, Peoria and partial Rockford rating areas
Medical Group Selection Required	No	No	No	Yes
Referral Required	No	No	No	Yes
OON Coverage	Yes	Yes	Yes	No
BlueCard®	Yes	Yes	Yes	Available for when members need emergency or urgent care services while outside their service areas, the BlueCard program will help them locate participating doctors and hospitals, allowing them to receive covered care.
Away From Home Care® (AFHC)	NA	NA	NA	No
Blue Access for Members	Yes	Yes	Yes	Yes
Provider Finder®	Yes	Yes	Yes	Yes
Member Liability Estimator	Yes	Yes	Yes	No

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