

FAX

TO:

Company:

Fax: 2814993197

Phone:

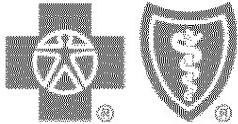
FROM : BCBS@hcsc.net

Fax:

Phone:

NOTES: Response to benefits inquiry over the phone.

The information contained in this communication is confidential, private, proprietary, or otherwise privileged and is intended only for the use of the addressee. Unauthorized use, disclosure, distribution or copying is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately at (312)653-6000 in Illinois; (800)447-7828 in Montana; (800)835-8699 in New Mexico; (918)560-3500 in Oklahoma; or (972)766-6900 in Texas.



Provider Fax Number 2814993197

Date of Inquiry - Confirmation # 01/28/2022-21327155

BlueCross BlueShield of Illinois

NPI, or Tax ID	272193992
Member Group and ID Number	019855 / 837018352
Patient Name	TREJO-CRUZ, ANTHONY

Product Type	PPO
Patient Date of Birth	2018-11-01
Effective Date	2018-11-01

COVERAGE INFORMATION

Benefit Category	GENERAL
In Network Benefits	Out of Network Benefits
Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00
Family Deductible	\$150.00
Benefit Maximum	\$2,000.00
Family Maximum	\$0.00
Out of pocket Maximum per Child	
Out of pocket Maximum per Family	
Maximum Dependent Age	26
Is Deductible Met	no
Waiting Period	no
Current Benefits Remaining	\$2,000.00
Missing Tooth Clause	No Missing Tooth Clause
Benefit Summary	No Missing Tooth Clause

Benefit Category	EXAMS
In Network Benefits	Out of Network Benefits
Individual Deductible	\$0.00
Class1 Annual Copay	\$0.00
Family Deductible	\$0.00
Benefit Maximum	\$2,000.00
Family Maximum	\$0.00
Out of pocket Maximum per Child	
Out of pocket Maximum per Family	
Waiting Period	Satisfied
Is Deductible Met	no
Coinsurance	100.0%
Lifetime Maximum	\$0.00
Last Date of Service	2021-11-04
Frequency	Twice per Calendar year.
Benefit Summary	Twice per Calendar year.

Benefit Category	CLEANINGS	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$0.00	Individual Deductible \$0.00
Class1 Annual Copay	\$0.00	Family Deductible \$0.00
Family Deductible	\$0.00	Benefit Maximum \$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 100.0%
Coinsurance	100.0%	Lifetime Maximum \$0.00
Lifetime Maximum	\$0.00	Last Date of Service 2021-11-04
Last Date of Service	2021-11-04	Frequency Twice per Calendar year.
Frequency	Twice per Calendar year.	Benefit Summary
Benefit Summary		

Benefit Category	EMERGENCY TREATMENT	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$0.00	Individual Deductible \$0.00
Class1 Annual Copay	\$0.00	Family Deductible \$0.00
Family Deductible	\$0.00	Benefit Maximum \$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 100.0%
Coinsurance	100.0%	Lifetime Maximum \$0.00
Lifetime Maximum	\$0.00	Last Date of Service
Last Date of Service		Frequency
Frequency		Benefit Summary
Benefit Summary		Benefits for this service may be covered, but are subject to professional review.

Benefit Category	BITEWING X-RAYS	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$0.00	Individual Deductible \$0.00
Class1 Annual Copay	\$0.00	Family Deductible \$0.00
Family Deductible	\$0.00	Benefit Maximum \$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 100.0%
Coinsurance	100.0%	Lifetime Maximum \$0.00
Lifetime Maximum	\$0.00	Last Date of Service
Last Date of Service		Frequency
Frequency		Benefit Summary
Benefit Summary		Twice per Calendar year.

Benefit Category

PANORAMIC X-RAYS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$0.00	Individual Deductible	\$0.00
Class1 Annual Copay	\$0.00	Family Deductible	\$0.00
Family Deductible	\$0.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	100.0%
Coinurance	100.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once per Calendar year.
Frequency	Once per Calendar year.	Benefit Summary	
Benefit Summary			

Benefit Category

FULL MOUTH X-RAYS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$0.00	Individual Deductible	\$0.00
Class1 Annual Copay	\$0.00	Family Deductible	\$0.00
Family Deductible	\$0.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	100.0%
Coinurance	100.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once per Calendar year.
Frequency	Once per Calendar year.	Benefit Summary	
Benefit Summary			

Benefit Category

FILLINGS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	80.0%
Coinurance	80.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once per Calendar year.
Frequency	Once per Calendar year.	Benefit Summary	
Benefit Summary			

Benefit Category	STAINLESS STEEL CROWNS
------------------	------------------------

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	80.0%
Coinsurance	80.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	
Frequency		Benefit Summary	
Benefit Summary			

Benefit Category	ENDODONTICS
------------------	-------------

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	80.0%
Coinsurance	80.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once per Lifetime per tooth.
Frequency	Once per Lifetime per tooth.	Benefit Summary	
Benefit Summary			

Benefit Category	ORAL SURGERY
------------------	--------------

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	80.0%
Coinsurance	80.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once per Lifetime per tooth.
Frequency	Once per Lifetime per tooth.	Benefit Summary	
Benefit Summary			

Benefit Category

PERIODONTICS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	80.0%
Coininsurance	80.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once every 12 months per tooth.
Frequency	Once every 12 months per tooth.	Benefit Summary	
Benefit Summary			

Benefit Category

CROWNS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	70.0%
Coininsurance	70.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once every 36 months per tooth.
Frequency	Once every 36 months per tooth.	Benefit Summary	
Benefit Summary			

Benefit Category

INLAYS AND ONLAYS

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$50.00	Individual Deductible	\$50.00
Class1 Annual Copay	\$0.00	Family Deductible	\$150.00
Family Deductible	\$150.00	Benefit Maximum	\$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	70.0%
Coininsurance	70.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	Once every 36 months per tooth.
Frequency	Once every 36 months per tooth.	Benefit Summary	
Benefit Summary			

Benefit Category	DENTURES	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$50.00	Individual Deductible \$50.00
Class1 Annual Copay	\$0.00	Family Deductible \$150.00
Family Deductible	\$150.00	Benefit Maximum \$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 50.0%
Coinsurance	50.0%	Lifetime Maximum \$0.00
Lifetime Maximum	\$0.00	Last Date of Service
Last Date of Service		Frequency Once every 36 months.
Frequency		Benefit Summary
Benefit Summary		

Benefit Category	BRIDGES	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$50.00	Individual Deductible \$50.00
Class1 Annual Copay	\$0.00	Family Deductible \$150.00
Family Deductible	\$150.00	Benefit Maximum \$2,000.00
Benefit Maximum	\$2,000.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 50.0%
Coinsurance	50.0%	Lifetime Maximum \$0.00
Lifetime Maximum	\$0.00	Last Date of Service
Last Date of Service		Frequency Once every 36 months per tooth.
Frequency		Benefit Summary
Benefit Summary		

Benefit Category	ORTHODONTICS	
	In Network Benefits	Out of Network Benefits
Individual Deductible	\$0.00	Individual Deductible \$0.00
Class1 Annual Copay	\$0.00	Family Deductible \$0.00
Family Deductible	\$0.00	Benefit Maximum \$0.00
Benefit Maximum	\$0.00	Family Maximum \$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child
Out of pocket Maximum per Child		Out of pocket Maximum per Family
Out of pocket Maximum per Family		Waiting Period Satisfied
Waiting Period	Satisfied	Is Deductible Met no
Is Deductible Met	no	Coinsurance 50.0%
Coinsurance	50.0%	Lifetime Maximum \$2,000.00
Lifetime Maximum	\$2,000.00	Last Date of Service
Last Date of Service		Frequency
Frequency		Benefit Summary
Benefit Summary		

Benefit Category

TMJ

In Network Benefits		Out of Network Benefits	
Individual Deductible	\$0.00	Individual Deductible	\$0.00
Class1 Annual Copay	\$0.00	Family Deductible	\$0.00
Family Deductible	\$0.00	Benefit Maximum	\$0.00
Benefit Maximum	\$0.00	Family Maximum	\$0.00
Family Maximum	\$0.00	Out of pocket Maximum per Child	
Out of pocket Maximum per Child		Out of pocket Maximum per Family	
Out of pocket Maximum per Family		Waiting Period	Satisfied
Waiting Period	Satisfied	Is Deductible Met	no
Is Deductible Met	no	Coinsurance	0.0%
Coinsurance	0.0%	Lifetime Maximum	\$0.00
Lifetime Maximum	\$0.00	Last Date of Service	
Last Date of Service		Frequency	
Frequency		Benefits for this service are not covered.	
Benefit Summary			

A quote of benefits is not a guarantee of payment unless otherwise required by law. All benefits are subject to the terms, conditions, limitations, and exclusions under the members policy, including the patient's effective status on the actual date of service.***All claims should be filed to the state in which the service was rendered unless otherwise specified under the members contract***

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

The information contained in this communication is confidential, private, proprietary, or otherwise privileged, and is intended only for the use of the addressee. Unauthorized use, disclosure, distribution or copying is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately at (312) 653-6000 in Illinois; (888) 826-8152 in Michigan; (866) 739-4090 in Montana; (800) 835-8699 in New Mexico; (918) 560-3500 in Oklahoma; or (972) 766-6900 in Texas. Once the sender has been notified, please destroy this document.