



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-772-6895 or at www.bcbsil.com/member/policy-forms.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$350 Individual/ \$700 Individual+1/ \$1,050 Family Doesn't apply to In-Network preventative care. Copays and per occurrence <u>deductibles</u> don't count toward the <u>deductible</u> . <u>Deductibles</u> apply to the Out-of-Pocket limit.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$150 deductible for Out-of-Network hospital admission. There are no other specific <u>deductibles</u> . <u>Deductibles</u> apply to the Out-of-Pocket limit.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For In-Network: \$1,500 Individual/ \$3,000 Individual+1/ \$4,000 Family For Out-of-Network: \$3,000 Individual/ \$9,000 Family Prescription drug expense limit: \$1,000 Individual/ \$2,700 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u> ?	Yes. For a list of In-Network Providers, see www.bcbsil.com or call 1-800-772-6895.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copay** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	30% coinsurance	---none---
	Specialist visit	15% coinsurance	30% coinsurance	---none---
	Other practitioner office visit	15% coinsurance	30% coinsurance	---none---
	Preventive care/screening/immunization	No Charge	No Charge	Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	20% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance	20% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com.</p>	Generic drugs	\$9 copay/prescription for up to a 30 day supply. \$18 copay/prescription for up to a 90 day supply.	\$9 copay/prescription for up to a 30 day supply.	30 day retail/90 day mail. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Formulary brand drugs	\$25 copay/prescription for up to a 30 day supply. \$50 copay/prescription for up to a 90 day supply.	\$25 copay/prescription for up to a 30 day supply.	For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the copay.
	Non-Formulary brand drugs	\$45 copay/prescription for up to a 30 day supply. \$90 copay/prescription for up to a 90 day supply.	\$45 copay/prescription for up to a 30 day supply.	RX Out-of-Pocket Expense Limit: \$1,000 Individual/\$2,700 Family
	Specialty drugs	\$100 copay/prescription for up to a 30 day supply. \$200 copay/prescription for up to a 90 day supply.	\$100 copay/prescription for up to a 30 day supply.	Coverage based on group policy.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	15% coinsurance	30% coinsurance	---none---
<p>If you need immediate medical attention</p>	Emergency room services	\$100 copay/visit plus 15% coinsurance	\$100 copay/visit plus 15% coinsurance	Copay waived if patient is admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	---none---
	Urgent care	15% coinsurance	30% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
	Physician/surgeon fee	15% coinsurance	20% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	30% coinsurance	---none---
	Mental/Behavioral health inpatient services	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
	Substance use disorder outpatient services	15% coinsurance	30% coinsurance	---none---
	Substance use disorder inpatient services	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
If you are pregnant	Prenatal and postnatal care	15% coinsurance	30% coinsurance	---none---
	Delivery and all inpatient services	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
	Rehabilitation services	15% coinsurance	30% coinsurance	---none---
	Habilitation services	15% coinsurance	30% coinsurance	---none---
	Skilled nursing care	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers. Limited to 120 days per calendar year.
	Durable medical equipment	15% coinsurance	30% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	15% coinsurance	20% coinsurance	\$150 deductible per admission for Out-of-Network providers.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care (with the exception of person with diagnosis of diabetes)
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (with the exception of inpatient private duty nursing)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-772-6895. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Illinois at 1-800-772-6895 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-772-6895.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-772-6895.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-772-6895.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-772-6895.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,930
- Patient pays \$1,610

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$400
Copays	\$10
Coinsurance	\$1,000
Limits or exclusions	\$200
Total	\$1,610

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,220
- Patient pays \$1,180

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$400
Copays	\$400
Coinsurance	\$300
Limits or exclusions	\$80
Total	\$1,180

Note: These examples are based on individual coverage only.

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copay**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copay**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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