



**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 at [www.bcbsil.com](http://www.bcbsil.com) or by calling 1-800-548-1686.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$500</b> Person/ <b>\$1,000</b> Family Doesn't apply to certain preventative care.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$2,600</b> Person/ <b>\$5,200</b> Family	The <b>out-of-pocket limit</b> 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, prescription charges, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Does this plan use a <u>network of providers</u> ?	Yes. Visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call <b>1-800-548-1686</b> for a list of Participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

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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.

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- **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**, **copayments** 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 copay /visit	Not Covered	---none---
	Specialist visit	\$40 copay /visit	Not Covered	---none---
	Other practitioner office visit	15% coinsurance	Not Covered	Chiropractic and Osteopathic manipulation services are limited to 30 visits per benefit period.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not Covered	---none---

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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><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsil.com">www.bcbsil.com</a>.</p>	Generic drugs	\$20 copay/ retail prescription drug \$40 copay/ mail order prescription drug	\$20 copay plus 25% coinsurance \$40 copay plus 25% coinsurance	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	\$40 copay/ retail prescription drug \$80 copay/ mail order prescription drug	\$40 copay plus 25% coinsurance \$80 copay plus 25% coinsurance	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	Non-Formulary brand drugs	\$60 copay/ retail prescription drug \$120 copay/ mail order prescription drug	\$60 copay plus 25% coinsurance \$120 copay plus 25% coinsurance	Dispensing limit may apply to certain drugs. Retail 34 day supply Mail order 90 day supply
	Specialty drugs	Covered	Not Covered	Oral medications and self injectables that are specialty drugs are covered as a standard benefit but are limited to a 30 day supply and are available only at retail.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not Covered	---none---
	Physician/surgeon fees	15% coinsurance	Not Covered	---none---
<p><b>If you need immediate medical attention</b></p>	Emergency room services	\$125 copay then 15% coinsurance	\$125 copay then 15% coinsurance	Copay waived if the member is admitted to the hospital.
	Emergency medical transportation	15% coinsurance	15% coinsurance	---none---
	Urgent care	15% coinsurance	Not Covered	---none---
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	15% coinsurance	Not Covered	---none---
	Physician/surgeon fee	15% coinsurance	Not Covered	---none---

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<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Your Cost If You Use an In-Network Provider</b>	<b>Your Cost If You Use an Out-of-Network Provider</b>	<b>Limitations &amp; Exceptions</b>
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	15% coinsurance	Not Covered	\$20 PCP copay applies to psychotherapy office visit only.
	Mental/Behavioral health inpatient services	15% coinsurance	Not Covered	---none---
	Substance use disorder outpatient services	15% coinsurance	Not Covered	\$20 PCP copay applies to psychotherapy office visit only.
	Substance use disorder inpatient services	15% coinsurance	Not Covered	---none---
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20 copay /visit	Not Covered	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	15% coinsurance	Not Covered	---none---
<b>If you need help recovering or have other special health needs</b>	Home health care	15% coinsurance	Not Covered	---none---
	Rehabilitation services	15% coinsurance	Not Covered	45 visit maximum per therapy for Occupational, Physical and Speech Therapies.
	Habilitation services	15% coinsurance	Not Covered	
	Skilled nursing care	15% coinsurance	Not Covered	---none---
	Durable medical equipment	15% coinsurance	Not Covered	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	Not Covered	Hospice requires pre certification through Blue Care Connection (BCC).
<b>If your child needs dental or eye care</b>	Eye exam	\$20 copay/visit	Not Covered	Exam is covered at 100% of billed charges after copay.
	Glasses	Covered	Not Covered	\$200 maximum per 24 month benefit period for materials for members age 19 and over.
	Dental check-up	Not Covered	Not Covered	---none---

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## 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
- Long Term Care
- Routine Foot Care (with the exception of person with diagnosis of diabetes)

### 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
- Infertility Treatment
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com)
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (with the exception of inpatient private duty nursing)
- Routine Eye Care (Adult)
- Weight Loss Program

## 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 1-800-548-1686. 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](http://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](http://www.cciio.cms.gov).

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## 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 1-800-548-1686 or visit [www.bcbsil.com](http://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](http://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 1-800-548-1686.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-548-1686.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-548-1686.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-548-1686.

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

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## 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 \$6,090
- Patient pays \$1,450

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$40
Coinsurance	\$760
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,450</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,680
- Patient pays \$1,720

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$500
Copays	\$960
Coinsurance	\$180
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,720</b>

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## 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**, **copayments**, 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 **copayments**, **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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