**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/cvs or by calling **1-888-775-6481**

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $**500/$1,000/$1,500** Individual<br>In-Network: **$1,000/$2,000/$3,000** Family<br>Out-of-Network: **$4,000** Individual/**$8,000** Family<br>Does not apply to copayments and certain In-Network Preventive Care. | You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible.** |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network: **$2,500/$4,000** Individual<br>For In-Network: **$6,250/$10,000** Family<br>For Out-of Network: **$7,500** Individual **/$20,000** Family | The **out-of-pocket-limit** 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 out–of–pocket limit?** | Premiums, balanced billed charges, copayments, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes.<br>Visit **www.bcbsil.com/cvs** or call **1-888-775-6481** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** 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 **excluded services**. |

- **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 provider's office or clinic** | Primary care visit to treat an injury or illness | $20 or $30 copayment/visit | 50% coinsurance | ---None--- |
| | Specialist visit | $45 or $50 copayment/visit | 50% coinsurance | ---None--- |
| | Other practitioner office visit | 20% coinsurance | 50% coinsurance | Chiropractic services up to 15 visits/plan year, combined In/Out-of-Network. |
| | Preventive care/screening/immunization | No Charge | Not Covered | Certain women's preventive service covered at no cost to member, In-network. For a full list of these services and/or prescriptions, contact Customer Service. Age and frequency schedules may apply to certain preventive care services; refer to your plan document (SPD) for further information. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | Preventive x-ray and blood work are covered at no charge, In-Network. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.caremark.com or by calling Caremark Customer Care at (866) 284-9226 | Generic drugs – 30-day supply<br><br>Generic drugs – 90-day supply – Value List<br><br>Generic drugs – 90 day supply<br><br>Standard and Value Formulary Options | $7.50 copayment per prescription<br>$9.99 copayment per prescription<br>$15 copayment per prescription | Not Covered | Deductible waived for preventive medications. No charge for formulary FDA approved women's oral contraceptives, In-Network. Infertility medications have a lifetime maximum of $10,000. Erectile Dysfunction medications are limited to 6 pills/month.<br><br>Maintenance medications must be filled as a 90 day supply at a CVS/pharmacy or through CVS Caremark Mail Order Pharmacy after two initial 30 day supplies are filled.<br><br>Under the *Standard Formulary Option*, if you get a brand drug when a generic is available, you will pay the generic co-payment or co-insurance plus the difference between the discounted cost of the generic and the brand drug.<br><br>Non-preferred brand drugs are not available under the *Value Formulary Option*<br><br>Over-the-counter medications and equipment are excluded.<br><br>There are Formulary exclusions. |
| | Preferred brand drugs – 30-day supply<br>Preferred brand drugs – 90-day supply<br><br>Standard and Value Formulary Options | 20% coinsurance<br>$41.50 copayment per prescription | Not Covered | |
| | Non-preferred brand drugs – 30-day supply<br>Non-preferred brand drugs – 90-day supply<br><br>Standard Formulary Option only | 35% coinsurance<br>$91 copayment per prescription | Not Covered | |
| | Specialty drugs | $75 copayment per prescription | Not Covered | 30-day supply available through CVS Caremark Specialty Pharmacy only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | ---None--- |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | If surgery is performed in the doctor's office, applicable copayment applies. |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance | $500 non-notification penalty for Out-of-Network. No coverage for non-emergency use. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | No coverage for non-emergency use. |
| | Urgent care | $50 copayment /visit | $50 copayment/visit | ---None--- |
| **If you have a** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | $500 non-notification penalty for Out-of-Network provider. |

| 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 |
|---|---|---|---|---|
| **hospital stay** | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | ---None--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 or $30 copayment/visit | 50% coinsurance | LifeScope For You EAP provides unlimited phone consults and up to 6 free in-person outpatient counseling sessions/issue/year with no prior authorization. Contact Life Scope for You EAP at 800-789-8990 or email: Help@4healthcare.com. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | $500 non-notification penalty for Out-of-Network provider. |
| | Substance use disorder outpatient services | $20 or $30 copayment/visit | 50% coinsurance | ---None--- |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | $500 non-notification penalty for Out-of-Network provider. |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | 50% coinsurance | A $20 or $30 copayment may apply for the initial visit to diagnose pregnancy. Lab and other tests during prenatal visits are subject to deductible and coinsurance. |
| | Delivery and all inpatient services | 20% coinsurance | 50% coinsurance | $500 non-notification penalty for Out-of-Network provider. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Up to 80 visits per plan year, combined In/Out-of-Network; $500 non-notification penalty for Out-of-Network. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Occupational/Physical therapy - Up to 60 visits/plan year, combined In/Out-of-Network.<br>Speech therapy – total of 40 visits/plan year, combined In/Out-of-Network. |
| | Habilitation services | Not Covered | Not Covered | ---None--- |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Total of 120 visits/plan year, combined In/Out-of-Network. $500 non-notification penalty for Out-of-Network. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | $7,500 maximum/plan year. Prosthetics not included in $7,500 max. Replacement every 3 plan years. |
| | Hospice service | 20% coinsurance | 50% coinsurance | $500 non-notification penalty for Out-of-Network provider. |
| **If your child** | Eye exam | Not Covered | Not Covered | ---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 |
|---|---|---|---|---|
| **needs dental or eye care** | Glasses | Not Covered | Not Covered | |
| | Dental check-up | Not Covered | Not Covered | |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Formulary exclusions
- Habilitation Services
- Hearing aids
- Long term care
- Over-the-counter medications and equipment (unless otherwise noted)
- Private duty nursing
- Routine eye care (Adult & Child) (including glasses)
- Routine foot care (except for diabetes)
- Weight loss programs

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

- Bariatric surgery (One per lifetime; pre-certification required; must use Blue Care Center of Distinction. See plan document for details.)
- Chiropractic care (Up to 15 visits/plan year)
- Infertility treatment ($10,000 lifetime maximum benefit; combined In/Out-of-Network for certain infertility services, provided requirements are met. Additional lifetime maximum benefit of $10,000 for infertility medications. See plan documents for details.)
- Most coverage provided outside the U.S. See www.bcbsil.com/CVS
- Non-emergency care when traveling outside the U.S.

## 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 1-888-775-6481. 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.

**Questions:** Call 1-888-775-6481 or visit us at **www.bcbsil.com/cvs**. 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.

## 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 Blue Shield of Illinois at 1-888-775-6481 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.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-775-6481.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-775-6481.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-775-6481.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-775-6481.

*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** $5,850
- **Patient pays** $ 1,690

**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 | $500 |
| Copays | $30 |
| Coinsurance | $1,010 |
| Limits or exclusions | $150 |
| **Total** | **$1,690** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,090
- **Patient pays** $1,310

**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 | $500 |
| Copays | $490 |
| Coinsurance | $240 |
| Limits or exclusions | $80 |
| **Total** | **$1,310** |

**Note: These examples are based on individual coverage only, Plan Option 1**

# 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.