### Important Questions

| What is the overall deductible? | Individual: Participating $6,000  
Non-Participating $15,000  
Family: Participating $13,100  
Non-Participating $45,000  
  Doesn’t apply to preventive care & certain copayments. | You must pay all the 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**. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
</tbody>
</table>
| Is there an out-of-pocket limit on my expenses? | Yes. Individual: Participating $6,000  
Non-Participating **Unlimited**  
Family: Participating $13,100  
Non-Participating **Unlimited** | 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, balance-billed charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |
| Does this plan use a network of providers? | Yes. See [www.bcbsil.com](http://www.bcbsil.com) or call 1-800-538-8833 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 don’t need a referral to see a specialist. | 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**. |

### Questions:

Call 1-800-538-8833 or visit us at [www.bcbsil.com/coverage](http://www.bcbsil.com/coverage).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](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 health 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.)

The plan may encourage you to use Participating providers by charging you lower deductibles, copayments, and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a Participating Provider</th>
<th>Your cost if you use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Acupuncture not covered. Chiropractic and Osteopathic Manipulation are limited to 25 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Formulary generic drugs</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Retail covers a 30 day supply and home delivery covers a 90 day supply. Non-Participating home delivery is not covered. Non-Participating specialty drug coverage is limited to certain medications that are clarified in the prescription drug rider. Generic drugs are not subject to the deductible.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_IL_5T_EX.pdf">https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_IL_5T_EX.pdf</a></td>
<td>Non-formulary generic drugs</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formulary brand drugs</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-formulary brand drugs</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a Participating Provider</td>
<td>Your cost if you use a Non-Participating Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees | No Charge                                     | 50% coinsurance                              | Abortions not covered, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed. |
| If you need immediate medical attention | Emergency room services  
Emergency medical transportation  
Urgent care | No Charge  
No Charge  
No Charge | No Charge  
No Charge  
50% coinsurance | Ground and air transportation covered.  
---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room)  
Physician/surgeon fee | No Charge  
No Charge | 50% coinsurance  
50% coinsurance | Inpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior.  
---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services  
Mental/Behavioral health inpatient services  
Substance use disorder outpatient services  
Substance use disorder inpatient services | No Charge  
No Charge  
No Charge  
No Charge | 50% coinsurance  
50% coinsurance  
50% coinsurance  
50% coinsurance | Pre-authorization is required for  
Psychological testing;  
Neuropsychological testing;  
Electroconvulsive therapy;  
Rhythmic Transcranial magnetic Stimulation;  
and Intensive Outpatient Treatment.  
Inpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior. |
| If you are pregnant | Prenatal and postnatal care  
Delivery and all inpatient services | No Charge  
No Charge | 50% coinsurance  
50% coinsurance | ---none--- |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a Participating Provider</th>
<th>Your cost if you use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Outpatient Services: Par, member may be balance billed if preauthorization not received within 15 days prior. Non-Par, $500 penalty if not preauthorized 2 business days prior. Inpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Outpatient Services: Par, member may be balance billed if preauthorization not received within 15 days prior. Non-Par, $500 penalty if not preauthorized 2 business days prior. Inpatient Services: Par, member will be responsible for the first $1,000 or 50%, whichever is less, if not preauthorized one business day prior. Non-Par, $500 penalty if not preauthorized one business day prior.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No Charge</td>
<td>Covered</td>
<td>One visit per year. Reimbursed up to $30 out-of-network. See benefit booklet for network details.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Covered</td>
<td>Covered</td>
<td>One pair of glasses per year. Reimbursed up to $45 out-of-network. See benefit booklet for network details.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>
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.)
- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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 (Limited to 25 visits per calendar year.)
- Cosmetic surgery (Only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (Two covered every 36 months for children or bone anchored)
- Infertility treatment
- Private-duty nursing (With the exception of inpatient private duty nursing)
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-538-8833. You may also contact your state insurance department at 1-877-527-9431.

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: Illinois Department of Insurance at (877) 527-9431 or visit [http://insurance.illinois.gov](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.
Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-538-8833.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-538-8833.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-538-8833.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-538-8833.

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 the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amount owed to providers: $7,540</td>
<td>• Amount owed to providers: $5,400</td>
</tr>
<tr>
<td>• Plan pays $1,340</td>
<td>• Plan pays $20</td>
</tr>
<tr>
<td>• Patient pays $6,200</td>
<td>• Patient pays $5,380</td>
</tr>
</tbody>
</table>

**Sample care costs:**

<table>
<thead>
<tr>
<th></th>
<th>(\text{Hospital charges (mother)})</th>
<th>(\text{Routine obstetric care})</th>
<th>(\text{Hospital charges (baby)})</th>
<th>(\text{Anesthesia})</th>
<th>(\text{Laboratory tests})</th>
<th>(\text{Prescriptions})</th>
<th>(\text{Radiology})</th>
<th>(\text{Vaccines, other preventive})</th>
<th>(\text{Total})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$2,700</td>
<td>$2,100</td>
<td>$900</td>
<td>$900</td>
<td>$500</td>
<td>$200</td>
<td>$200</td>
<td>$40</td>
<td>$7,540</td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th></th>
<th>(\text{Deductibles})</th>
<th>(\text{Copays})</th>
<th>(\text{Coinsurance})</th>
<th>(\text{Limits or exclusions})</th>
<th>(\text{Total})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$6,000</td>
<td>$0</td>
<td>$0</td>
<td>$200</td>
<td>$6,200</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$6,200</td>
</tr>
</tbody>
</table>
Questions and answers about 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.

Questions: Call 1-800-538-8833 or visit us at www.bcbsil.com/coverage. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.