BlueCross BlueShield of Illinois

McDonald's Licensees and Ronald McDonald House Charities Health & Welfare Plan Trust: Health Plan 4

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-730-8445 or at https://policy-srv.box.com/s/gtz2sl0cdjo2erxhbqkhwnwpr9n1u7uw.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $600 Individual/$1,200 Family For Out-of-Network: $1,200 Individual/$2,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and services that charge a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $500 deductible for In-network and Out-of-Network hospital admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For In-Network: $6,500 Individual/$13,000 Family For Out-of-Network: $13,000 Individual/$26,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com/licensees or call 1-800-730-8445 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit; deductible does not apply	50% coinsurance	Virtual visit; $10 copayment/visit, deductible does not apply. See your benefit booklets for details.
	Specialist visit	$30/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-approval of high cost/high tech procedures is recommended.

* For more information about limitations and exceptions, see the plan or policy document at

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com/mcdonalds or by calling 1-877-783-2268 Prescription drug coverage is issued by Fidelity Security Life Insurance Company.	Generic drugs	$10 copay at retail/ $25 copay by mail order	Pay 100% at the retail pharmacy and submit a completed claim form to Express Scripts (ESI)	Covers up to a 30-day supply (retail prescription); up to a 90-day supply by mail order (Express Script's or Walgreen's). Preventative drug Copays are "$0.00". After 2 fills for maintenance drugs, the member must obtain the prescription for a 90 day supply at mail order. You pay the difference in cost if you request a brand name drug instead of its generic equivalent for all drugs. Non-participating provider at mail is not covered for all prescriptions. Certain specialty drugs used to treat complex conditions must be purchased through Accredo (a division of the ESI Pharmacy for specialty drugs) for all fills of your prescription, including your first fill. Any differences between the cost of the generic drug and the cost of the brand name drug will apply to the deductible or out-of-pocket maximum. The applicable cost-sharing (by tier) and the cost difference between the generic and brand will never exceed the overall cost of the drug.
	Preferred brand drugs	40% co-insurance with $50 min & $300 max at retail 40% co-insurance with $125 min & $750 max by mail order	Pay 100% at the retail pharmacy and submit a completed claim form to Express Scripts (ESI)	
	Non-preferred brand drugs	50% co-insurance with $100 min & $500 max at retail 50% co-insurance with $250 min & $1250 max by mail order	Pay 100% at the retail pharmacy and submit a completed claim form to Express Scripts (ESI)	
	Specialty drugs	Same cost sharing as retail	Same cost sharing as retail	Certain specialty drugs used to treat complex conditions must be purchased through Accredo (a division of the ESI Pharmacy for specialty drugs) for all fills of your prescription, including your first fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-Emergent use of the emergency room has a 30% coinsurance after deductible for both In-Network and Out-of-Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 deductible per admission plus 20% coinsurance	$500 deductible per admission plus 50% coinsurance	Precertification is required. Failure to pre-certify services is a 50% benefit reduction with a $1,000 maximum penalty limit.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	$30 copayment applies to office visits only. Virtual visit; $10 copayment/visit, deductible does not apply. See your benefit booklets for details.
	Inpatient services	$500 deductible per admission plus 20% coinsurance	$500 deductible per admission plus 50% coinsurance	Precertification is required. Residential treatment services covered.
If you are pregnant	Office visits	$30/visit; deductible does not apply	50% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$500 deductible per admission plus 20% coinsurance	$500 deductible per admission plus 50% coinsurance	Precertification is required.

* For more information about limitations and exceptions, see the plan or policy document at

https://policy-srv.box.com/s/gtz2sl0cdjo2erxhbqkhwnwpr9n1u7uw.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visit limit combined with private duty nursing. Precertification is required.
	Rehabilitation services	20% coinsurance	50% coinsurance	60 combined visits for speech, occupational, and physical therapies.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	$500 deductible per admission plus 20% coinsurance	$500 deductible per admission plus 50% coinsurance	Limited to a 120-day maximum. Precertification is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	$500 deductible per admission plus 20% coinsurance	$500 deductible per admission plus 50% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Benefits available through EyeMed.
	Children's glasses	Not Covered	Not Covered	Benefits available through EyeMed.
	Children's dental check-up	Not Covered	Not Covered	Benefits available through Delta Dental.

Excluded services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 20 visits per calendar year)
- Hearing aids (for children 1 per ear, every 24 months, for adults up to $2,500 per ear every 24 months)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Private-duty nursing (with the exception of inpatient private duty nursing)
- Routine foot care (Only in connection with diabetes)

* For more information about limitations and exceptions, see the plan or policy document at

https://policy-srv.box.com/s/gtz2sl0cdjo2erxhbqkhwnwpr9n1u7uw.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-730-8445, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-730-8445 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 plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-730-8445.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-730-8445.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-730-8445

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-730-8445.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$600**
Specialist copayment	**$30**
Hospital (facility) both	**$500+20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$40
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$600**
Specialist copayment	**$30**
Hospital (facility) both	**$500+20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$600**
Specialist copayment	**$30**
Hospital (facility) both	**$500+20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$70
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,070**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsfWashington, DC 20201
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodiílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.


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