BlueCross BlueShield of Illinois : **Blue Precision Bronze HMO℠ 205**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company



**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, visit www.bcbsil.com/bb/ind/bb_bh3h31baviilp_il_2024.pdf or by calling 1-800-892-2803. 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?** | $0 at Indian Health Care Provider or with IHCP referral at non-IHCP; or<br>Individual: Participating $7,400<br>Family: Participating $14,800 | 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. Services from Indian Health Care Providers and In-Network Preventive Health Care services and certain services with 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 www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Individual: Participating $9,450<br>Family: Participating $18,900 | 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, balance billing 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.bcbsil.com/blueprecisionhmo or call 1-800-892-2803 for a list of Participating Providers. | You pay the least if you use a provider in IHCP Network. You pay more if you use a provider in Non-IHCP 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?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No Charge | $65/visit; deductible does not apply | Not Covered | None |
| | Specialist visit | No Charge | $105/visit; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Preventive care/screening/ immunization | No Charge | No Charge; deductible does not apply | Not Covered | 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) | No Charge | $100/lab, $150/X-Ray; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Imaging (CT/PET scans, MRIs) | No Charge | $300/test; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |


*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_bh3h31baviilp_il_2024.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsil.com/rx24h/6T | Generic drugs (Preferred) | No Charge | 10% coinsurance | Not Covered | Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. 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. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $100, when obtained from a Participating Pharmacy. |
| | Generic drugs (Non-Preferred) | No Charge | 15% coinsurance | Not Covered | |
| | Brand drugs (Preferred) | No Charge | 20% coinsurance | Not Covered | |
| | Brand drugs (Non-Preferred) | No Charge | 30% coinsurance | Not Covered | |
| | Specialty drugs (Preferred) | No Charge | 40% coinsurance | Not Covered | |
| | Specialty drugs (Non-Preferred) | No Charge | 50% coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | $300/visit plus 50% coinsurance | Not Covered | Referral required.<br>For Outpatient Infusion Therapy, see your benefit booklet* for details.<br>Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No Charge | $150/visit; deductible does not apply | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | No Charge | $1,000/visit plus 50% coinsurance | $1,000/visit plus 50% coinsurance | Per occurrence copayment waived upon inpatient admission. Cost sharing waived at non-IHCP with IHCP referral. |
| | Emergency medical transportation | No Charge | 50% coinsurance | 50% coinsurance | Cost sharing waived at non-IHCP with IHCP referral. |
| | Urgent care | No Charge | $105/visit; deductible does not apply | Not Covered | Must be affiliated with member's chosen medical group or referral required. Cost sharing waived at non-IHCP with IHCP referral. |


*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_bh3h31baviilp_il_2024.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | $850/day; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No Charge | No Charge; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | $65/office visit; deductible does not apply<br>50% coinsurance for other outpatient services | Not Covered | Referral may be required. Telepsychiatry benefits are available; see your benefit booklet* for details. Cost sharing waived at non-IHCP with IHCP referral. |
| | Inpatient services | No Charge | $850/day; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you are pregnant** | Office visits | No Charge | Primary Care: $65<br>Specialist: $105; deductible does not apply | Not Covered | Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, |


*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_bh3h31baviilp_il_2024.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | No Charge | No Charge; deductible does not apply | Not Covered | coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral. |
| | Childbirth/delivery facility services | No Charge | $850/day; deductible does not apply | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Rehabilitation services | No Charge | $65/visit; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Habilitation services | No Charge | $65/visit; deductible does not apply | Not Covered | |
| | Skilled nursing care | No Charge | $500/day; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Durable medical equipment | No Charge | No Charge; deductible does not apply | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Hospice services | No Charge | 50% coinsurance | Not Covered | Referral required. Cost sharing waived at non-IHCP with IHCP referral. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | No Charge; deductible does not apply | Not Covered | One visit per year. See your benefit booklet* for details. |
| | Children's glasses | No Charge | No Charge; deductible does not apply | Not Covered | One pair of glasses per year up to age 19. See your benefit booklet* for details. |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered | None |


*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_bh3h31baviilp_il_2024.pdf.

## 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
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion care
- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation 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 (for children 1 per ear every 24 months, for adults up to $2,500 per ear every 24 months)
- Infertility treatment (covered for 4 procedures per benefit period)
- Private-duty nursing (with the exception of inpatient private-duty nursing)
- Routine eye care (Adult, 1 visit per benefit period)
- Routine foot care (when medically necessary)

**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 1-800-892-2803. You may also contact your state insurance department at 1-877-527-9431. 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 on how 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 Illinois at 1-800-892-2803 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 1-877-527-9431 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?** **Not Applicable**
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 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

*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 | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$60** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$20** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-236-1702.
Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association
SBC-IL-HMO-IND-2024

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

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

**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
Washington, DC 20201

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

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

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<br>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<br>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<br>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<br>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<br>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<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખચેર્, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો. |
| हिंदी<br>Hindi | यिद आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा म निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक स बात करन क लिए 855-710-6984 पर कॉल करें।. |
| Italiano<br>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<br>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<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| فارسی<br>Persian | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی 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<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezplatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>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<br>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<br>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<br>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. |