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/static/il/pdf/policy-forms/2017/36096IL0810072-00.pdf or by calling 1-800-538-8833.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$5,500** Family: Participating **$14,300** 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**.
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. Individual: Participating **$7,150** Family: Participating **$14,300**	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 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?	Yes. All specialist visits require a written PCP referral unless it's for an OB/GYN or for emergency care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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 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.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	Not Covered	Virtual visits may be available, please refer to your plan policy for more details.
	Specialist visit	$50 copayment/visit	Not Covered	Referral Required.
	Other practitioner office visit	$50 copayment/visit	Not Covered	Acupuncture not covered. Chiropractic and Osteopathic Manipulation are limited to 25 visits per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	Hospital - $80 copayment/visit Non-Hospital - $40 copayment/visit	Not Covered	Referral Required.
	Imaging (CT / PET scans, MRIs)	Hospital - $350 copayment/visit Non-Hospital - $175 copayment/visit	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_IL_5T_EX.pdf	Formulary generic drugs	No Charge	Not Covered	Retail covers a 30 day supply and home delivery covers a 90 day supply. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 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 generic drugs	10% coinsurance	Not Covered	
	Formulary brand drugs	20% coinsurance	Not Covered	
	Non-formulary brand drugs	30% coinsurance	Not Covered	
	Specialty drugs	40% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital - $400 copayment/visit plus 50% coinsurance Non-Hospital - $400 copayment/visti plus 30% coinsurance	Not Covered	Referral required. 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.
	Physician/surgeon fees	$75 copayment/visit	Not Covered	
If you need immediate medical attention	Emergency room services	$700 copayment/visit plus 30% coinsurance	$700 copayment/visit plus 30% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Ground and air transportation.
	Urgent care	$50 copayment/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/visit plus 30% coinsurance	Not Covered	Referral Required.
	Physician/surgeon fee	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment for office visits or 30% coinsurance for other outpatient services	Not Covered	Referral Required. Virtual visits may be available for Outpatient services, please refer to your plan policy for more details.
	Mental/Behavioral health inpatient services	$500 copayment/visit plus 30% coinsurance	Not Covered	
	Substance use disorder outpatient services	$25 copayment for office visits or 30% coinsurance for other outpatient services	Not Covered	
	Substance use disorder inpatient services	$500 copayment/visit plus 30% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	$25 copayment	Not Covered	Copyament applies to first prenatal visit per pregnancy.
	Delivery and all inpatient services	$500 copayment/visit plus 30% coinsurance	Not Covered	Referral required.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Referral required.
	Rehabilitation services	$50 copayment/visit	Not Covered	
	Habilitation services	$50 copayment/visit	Not Covered	
	Skilled nursing care	30% coinsurance	Not Covered	
	Durable medical equipment	30% 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	30% coinsurance	Not Covered	Referral required.
If your child needs dental or eye care	Eye exam	No Charge	Covered	One visit per year. Reimbursed up to $30 out-of-network. See benefit booklet for network details.
	Glasses	Covered	Covered	One pair of glasses per year. Reimbursed up to $45 out-of-network. See benefit booklet for network details.
	Dental check-up	Not Covered	Not Covered	---none---

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.

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $840
- **Patient pays** $6,700

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	$5,500
Copays	$500
Coinsurance	$500
Limits or exclusions	$200
Total	**$6,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

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	$2,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,480**

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.