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 or by calling 1-800-292-6398.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network **$350** Individual/**$700** Family For Out-of-Network **$1,000** Individual/**$2,000** Family Doesn't apply to certain preventive care.	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?	For In-network **$1,000** Individual/**$2,000** Family For Out-of-network **$2,000** Individual/**$4,000** 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, deductibles, copayments, 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart 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. Visit **www.bcbsil.com** or call **1-800-292-6398** 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**, **copay** 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	10% coinsurance	$25 copay/visit and 30% coinsurance	Copay applies to office visit only.
	Specialist visit	10% coinsurance	$25 copay/visit and 30% coinsurance	
	Other practitioner office visit	10% coinsurance	$25 copay/visit and 30% coinsurance	36 visits benefit period maximum for Chiropractic services.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Pre-authorization required by Telligen.

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 More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 copay/retail prescription $10 copay/mail order prescription	100%	Retail: 1-30 day supply Mail Order: 31-90 day supply Not all prescriptions are covered. To determine if a specific drug is covered under your plan, log into your account at caremark.com and use the Check Drug Coverage and Cost tool.
	Preferred brand drugs	$15 copay/retail prescription $30 copay/mail order prescription	100%	Retail: 1-30 day supply Mail Order: 31-90 day supply Not all prescriptions are covered. To determine if a specific drug is covered under your plan, log into your account at caremark.com and use the Check Drug Coverage and Cost tool.
	Non-preferred brand drugs	$35 copay/retail prescription $70 copay/mail order prescription	100%	Retail: 1-30 day supply Mail Order: 31-90 day supply Not all prescriptions are covered. To determine if a specific drug is covered under your plan, log into your account at caremark.com and use the Check Drug Coverage and Cost tool.
	Specialty drugs	Covered, with applicable copay levels as shown above.	100%	Retail: 1-30 day supply Mail Order: 31-90 day supply Not all prescriptions are covered. To determine if a specific drug is covered under your plan, log into your account at caremark.com and use the Check Drug Coverage and Cost tool.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	30% 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 immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay waived if patient is admitted. Call Telligen within one work day if admitted. More information about these services is available at www.telligen.qualitrac.com or call 1-800-848-7207. Failure to call will result in a 20% decrease in benefit payment.
	Emergency medical transportation	30% coinsurance	30% coinsurance	---none---
	Urgent care	10% coinsurance	$25 copay/visit and 30% coinsurance	Deductible Applies
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Call Telligen within one work day if admitted. More information about these services is available at www.telligen.qualitrac.com or call 1-800-848-7207.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	$25 copay/visit and 30% coinsurance	30 visits per year combined with substance abuse: treatment must be pre-authorized by ComPsych otherwise may be subject to a 20% reduction. More information about these services is available at www. www.guidanceresources.com
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Must contact ComPsych within 1 business day, otherwise subject to a 20% reduction.
	Substance use disorder outpatient services	10% coinsurance	$25 copay/visit and 30% coinsurance	Dependent coverage only available as required by PPACA. 30 visits per year combined with mental health; Treatment must be approved by CTA and ComPsych or it will not be covered.
	Substance use disorder inpatient services	30% coinsurance	30% coinsurance	Dependent coverage only available as required by PPACA. 3 Treatments per lifetime; Treatments must be approved by CTA and ComPsych or it will not be covered. More information about these services is available at www.guidanceresources.com
If you are pregnant	Prenatal and postnatal care	10% coinsurance	$25 copay/visit and 30% 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
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Call Telligen within one work day if admitted. More information about these services is available at www.telligen.qualitrac.com or call 1-800-848-7207. Failure to call will result in a 20% decrease in benefit payment.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	40 visits per benefit period.
	Rehabilitation services	10% coinsurance	30% coinsurance	---none---
	Habilitation services	10% coinsurance	30% coinsurance	These types of services are covered under the Autism diagnosis with limitations.
	Skilled nursing care	10% coinsurance	30% coinsurance	---none---
	Durable medical equipment	10% coinsurance	30% coinsurance	---none---
	Hospice service	10% coinsurance	30% coinsurance	---none---
If your child needs dental or eye care	Eye exam	Covered	Covered	Dependent coverage only available as required by PPACA.
	Glasses	Covered	Covered	
	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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Routine Foot Care (with the exception of those with diabetes)
- 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.)

- Chiropractic Care
- Bariatric Surgery
- Most coverage outside the United States. See www.bcbsil.com
- Non-Emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Private Duty Nursing (excluding inpatient services)

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 1-800-292-6398. 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.

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 a Customer Service representative to help you file your appeal. Please contact Customer Service at 1-800-292-6398. In addition, a list of states with additional Consumer Assistance Programs is available at http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-292-6398.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-292-6398.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-292-6398.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-292-6398.

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** $6,340
- **Patient pays** $1,200

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	$350
Copays	$10
Coinsurance	$690
Limits or exclusions	$150
Total	**$1,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,550
- **Patient pays** $850

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	$350
Copays	$200
Coinsurance	$220
Limits or exclusions	$80
Total	**$850**

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**, **copay**, 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 **copay**, **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.