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 http://www.bcbsil.com/policy-forms/2018/IL0810083-00.pdf or by calling 1-800-538-8833. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating $6,000 Family: Participating $14,700	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?	Doesn't apply to preventive care & certain copayments.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual: Participating $7,350 Family: Participating $14,700	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-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.
Will you pay less if you use a network provider?	See www.bcbsil.com or call **1-800-538-8833** for a list of Participating 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?	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 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
		Participating Provider (You will pay the least)	Non-Participating 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	$50/visit, deductible does not apply	Not Covered	None.
	Specialist visit	$85/visit, deductible does not apply	Not Covered	Referral Required.
	Preventive care/screening/ immunization	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)	Hospital - $200/visit Non-Hospital - $100/visit, deductible does not apply	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	Hospital - $600/visit Non-Hospital - $300/visit, deductible does not apply	Not Covered	Referral required.
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	Preferred generic drugs	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 limited to a 30-day supply. 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. You may be eligible to synchronize your prescription refills, *please see your benefit booklet for details.
	Non-preferred generic drugs	15% coinsurance	Not Covered	
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	30% coinsurance	Not Covered	
	Preferred specialty drugs	40% coinsurance	Not Covered	
	Non-Preferred specialty drugs	50% coinsurance	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/policy-forms/2018/IL0810083-00.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital - $300/visit plus 50% coinsurance Non-Hospital - $300/visit plus 40% 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	$150/visit, deductible does not apply	Not Covered	
If you need immediate medical attention	Emergency room care	$1,000/visit plus 40% coinsurance	$1,000/visit plus 40% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Ground and air transportation covered.
	Urgent care	$85/visit, deductible does not apply	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)	$850/day, deductible does not apply	Not Covered	Referral required. copayment applies per day until the Out-of-Pocket limit has been met.
	Physician/surgeon fees	40% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/visit or 40% 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.
	Inpatient services	$850/day	Not Covered	
If you are pregnant	Office visits	Primary Care - $50/visit Specialist - $85/visit	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient copayment is charged in addition to the overall deductible. Service provided at no charge with CHS referral.
	Childbirth/delivery professional services	40% coinsurance	Not Covered	
	Childbirth/delivery facility services	$850/day	Not Covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Referral required.
	Rehabilitation services	$70/visit, deductible does not apply	Not Covered	
	Habilitation services	$70/visit, deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Skilled nursing care	$500/day, deductible does not apply	Not Covered	
	Durable medical equipment	40% 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 services	40% coinsurance	Not Covered	Referral required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One visit per year. *See benefit booklet for network details.
	Children's glasses	No Charge	Not Covered	One pair of glasses per year. *See benefit booklet for network details.
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- 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.
- Weight loss programs

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

- 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 (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 (Only in connection with diabetes)

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/policy-forms/2018/IL0810083-00.pdf.

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 1-800-538-8833. 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 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 1-800-538-8833 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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): 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 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	$6,000
Specialist copayment	$85
Hospital (facility) copayment	$850
Other coinsurance	40%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	$6,000
Specialist copayment	$85
Hospital (facility) copayment	$850
Other coinsurance	40%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,760**

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

The plan's overall deductible	$6,000
Specialist copayment	$85
Hospital (facility) copayment	$850
Other coinsurance	40%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 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 إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 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, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 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, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 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 Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર 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, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 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 servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, 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. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné 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. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
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 podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, 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 поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 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 comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 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 numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, 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، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

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 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
Email: CivilRightsCoordinator@hcsc.net

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

Blue Precision Bronze HMO^{SM} 205
Blue Precision HMO^{SM}

OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. — This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Blue Precision HMO – Blue Precision HMO provides, to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services and Out-of-Hospital care, subject to any deductibles, Copayments or other limitations which may be set forth in your Policy. **To be covered under the Policy, the services you receive must be provided by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider, except in certain situations such as emergencies.** To receive benefits for treatment from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider. The referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

BASIC PROVISIONS	**Blue Precision Bronze HMO 205**
	YOUR COST
Deductible Per individual, per calendar year	$6,000*
Family Aggregate Deductible Per family, per calendar year	$14,700*
Out-of-Pocket Expense Limitation* (does not apply to all services) Individual Family	 $7,350 $14,700
NOTE: *Covered Services for sterilization procedures are covered at no cost to you when the services are ordered by your Primary Care Physician or Woman's Principal Health Care Provider.*	
PHYSICIAN BENEFITS	
Copayment for Outpatient Physician office visits	$50 per Visit
Copayment for Outpatient Specialist office visits	$85 per Visit

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BASIC PROVISIONS	Blue Precision Bronze HMO 205
	YOUR COST
Preventive Care Services Benefits will be provided for the following Covered Services and will not be subject to Coinsurance, deductible, Copayment or dollar maximum (to be implemented in the quantity and at the time required by applicable law or regulatory guidance): Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and prevention with respect to the individual involved; evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).	None
Copayment for Outpatient Occupational, Physical and Speech Therapy Treatments	$70 per Treatment
Copayment for Outpatient Surgery	$150 per Visit
Outpatient Office Visits for the Treatment of Mental Illness Other Than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Care Provider	50% of Provider's Charge per Visit
HOSPITAL BENEFITS	
Copayment for Inpatient Hospital Admission	$850 per Day
Copayment for Skilled Nursing Facility	$500 per Day
Inpatient Treatment of Mental Illness Other than Serious Mental Illness When Not Authorized by Primary Care Physician or Woman's Principal Health Care Provider	50% of the Eligible Charge
Copayment for Outpatient Surgery	
Free Standing Facility	$300 per Visit, then 40% of the Eligible Charge
Hospital	$300 per Visit, then 50% of the Eligible Charge
Copayment for Certain Diagnostic Tests: **Computerized Tomography (CT Scan)** **Positron Emission Tomography (PET Scan)** **Magnetic Resonance Imaging (MRI):**	
Free Standing Facility	$300 per Procedure
Hospital	$600 per Procedure
Copayment for Outpatient Laboratory Services:	
Free Standing Facility	$50 per Procedure
Hospital	$100 per Procedure

BASIC PROVISIONS	Blue Precision Bronze HMO 205
	YOUR COST
Copayment for Outpatient Diagnostic X-Ray Services: Free Standing Facility Hospital	 $100 per Procedure $200 per Procedure
Copayment for Urgent Care	$85 per Visit
All Other Outpatient Covered Services	40% of the Eligible Charge
SUPPLEMENTAL BENEFITS	
Supplemental Benefits Blood and blood components; Outpatient Private Duty Nursing, medical and surgical dressings, supplies, casts and splints, oxygen and its administration, naprapathic services, prosthetic devices, orthotic devices and durable medical equipment	40% of the Eligible Charge
EMERGENCY CARE SERVICES BENEFITS	
Copayment for Emergency Care Services (In-Area or Out-of-Area)	$1,000 per Visit, then 40% of the Eligible Charge *(deductible waived if admitted to Hospital as an Inpatient immediately following emergency treatment)*
Emergency Ambulance Transportation	40% of the Eligible Charge
SUBSTANCE USE DISORDER BENEFITS	
Copayment for Inpatient Hospital Admission for Substance Use Disorder Treatment	$850 per Day
Copayment for Outpatient office visits for Substance Use Disorder Treatment	$50 per Visit
Copayment for Outpatient specialist office visits for Substance Use Disorder Treatment	$50 per Visit

OUTPATIENT PRESCRIPTION DRUG PROGRAM	
Please refer to the Outpatient Prescription Drug Program Section of the Policy for additional information regarding how payment is determined. However, you may receive coverage for up to a 12-month supply for dispensed contraceptives. Benefits are available for contraceptive drugs and products shown on the *Women's Contraceptive Coverage List* and will not be subject to any deductible, Coinsurance Amount, and/or Copayment Amount when received from a Participating Pharmacy Provider. Your share of the cost for all other contraceptives drugs and products will be provided as shown below. If you or your Provider requests a Brand Name Drug when a generic or therapeutic equivalent is available, you will be responsible for the Non-Preferred Brand Name Drug payment amount, plus the difference in cost between the Brand Name Drug and the generic or therapeutic equivalent, except as otherwise provided in the Policy.	
30-Day Supply Outpatient Prescription Drug Program	
Tier 1	10% of the Eligible Charge per Prescription
Tier 2	15% of the Eligible Charge per Prescription
Tier 3	20% of the Eligible Charge per Prescription
Tier 4	30% of the Eligible Charge per Prescription
Tier 5	40% of the Eligible Charge per Prescription
Tier 6	50% of the Eligible Charge per Prescription
90-Day Supply Outpatient Prescription Drug Program	
Tier 1	10% of the Eligible Charge per Prescription
Tier 2	15% of the Eligible Charge per Prescription
Tier 3	20% of the Eligible Charge per Prescription
Tier 4	30% of the Eligible Charge per Prescription
DEPENDENT LIMITING AGE	
Limiting Age for Dependent Children *(regardless of presence or absence of child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors)* *(In addition, enrolled unmarried children will be covered up to the age of 30 if they live within the service area of the Plan network for the Policy; and have served as an active or reserve member of any branch of the Armed Forces of the United States; and have received a release or discharge other than a dishonorable discharge.)*	26

PEDIATRIC VISION CARE SERVICES For Covered Persons Under Age 19	
Routine Exams (does not include professional services for contract lenses), Lenses, and Provider-Designated Frames and Contact Lenses	None
Low vision services and Laser vision correction Surgery (LASIK)	Traditional and custom LASIK Surgery will be available at a discount from Participating Physicians and affiliated laser centers.

* The program deductible and Out-of-Pocket Expense Limitation amounts may be subject to change or increase as permitted by applicable law or regulatory guidance.

GUARANTEED RENEWABILITY

Coverage under the Policy will be terminated for nonpayment of premiums. Blue Cross and Blue Shield may terminate or refuse to renew the Policy for any of the following reasons:

1. If every Policy that bears the Policy form number, is not renewed. If every Policy that bears the same Group Number, is not renewed or if Blue Cross and Blue Shield ceases to offer a particular type of coverage in the individual market. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
   c. If Blue Cross and Blue Shield should terminate or refuse to terminate the Policy, it must do so uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
2. If Blue Cross and Blue Shield discontinue all health care coverage and does not renew all health insurance policies it issues or delivers for issuance in the individual market in the state. If this should occur, Blue Cross and Blue Shield will give you at least 180 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
3. In the event of fraud or an intentional misrepresentation of material fact under the terms of the Policy. In this case, Blue Cross and Blue Shield will give you at least 30 days prior written notice, or such other notice, if any, permitted by applicable law or regulatory guidance.
4. You no longer reside, live or work in the Blue Cross and Blue Shield's network service area.
5. Failure to pay your premium in accordance with the terms of the Policy. When you renew Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.
6. Other reasons described in the Policy.

Blue Cross and Blue Shield will never terminate or refuse to renew the Policy because of the condition of your health.

EXCLUSIONS AND LIMITATIONS:

Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, HOSPITAL BENEFITS section and for Mental Illness (other than Serious Mental Illness) or for routine vision examinations, PHYSICIAN BENEFITS section of the Policy.

Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated, unless otherwise stated in the Policy.

Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, (except in the case of Medicare), except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. Ch. 23 §1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that Blue Cross and Blue Shield has provided benefits for the services or supplies rendered in connection with such injury.

Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature, except as specifically provided for in the Policy for a) the cost of routine patient care associated with Experimental/Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under the Policy if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

Custodial Care Service.

Long Term Care Services.

Respite Care Services, except as specifically mentioned under the Hospice Care Benefits section of the Policy.

Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Special education therapy such as music therapy or recreational therapy, except as specifically provided for in the Policy.

Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.

Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.

Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in the Policy.

Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience to the patient or unrelated to the treatment of disease or injury.

Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements, except as stated in the Policy.

Blood derivatives which are not classified as drugs in the official formularies.

Hypnotism.

Inpatient Private Duty Nursing Service.

Routine foot care, except for persons diagnosed with diabetes.

Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically stated in the Policy.

Maintenance Care.

Self-management training, education and medical nutrition therapy, except as specifically stated in the Policy.

Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in the Policy.

Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in the Policy.

Services or supplies rendered for human organ or tissue transplants except as specifically provided for in the Policy.

Wigs (also referred to as cranial prostheses) unless otherwise specified in the Policy.

Services or supplies rendered for infertility treatment, except as specifically provided for in the Policy.

Eyeglasses, contact lenses which are not medically necessary and/or hearing aids, except as specifically provided for in the Policy.

Acupuncture.

Reversal of vasectomies.

Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.

Any service and/or supplies provided to you outside of the United States, unless they are received for an Emergency Condition, notwithstanding any provision in the Policy to the contrary.

Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in the Policy.