



**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 <http://www.bcbsil.com/cvs> or by calling 1-888-775-6481.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In-Network: <b>\$3,000</b> Individual/ <b>\$6,000</b> Family Out-of-Network: <b>\$6,000</b> Individual/ <b>\$12,000</b> Family Doesn't apply to In-Network Preventive Care. <i>Covered non-preventive services apply to your combined medical and Rx deductible. The full IND deductible must be met if you cover yourself only and the full FAM deductible must be met if you cover yourself and one or more dependents.</i>	You must pay all costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No. There are no other <b>deductibles</b> .	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. In-Network: <b>\$6,000</b> Individual/ <b>\$12,000</b> Family Out-of-Network: <b>\$12,000</b> Individual/ <b>\$24,000</b> Family	The <b>out-of-pocket-limit</b> 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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balanced billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes, this plan uses <b>network providers</b> . If you use a <b>non-network provider</b> your cost may be more. For a list of <b>network providers</b> , visit <a href="http://www.bcbsil.com/cvs">http://www.bcbsil.com/cvs</a> or call 1-888-775-6481.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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 <b>excluded services</b> .

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.



- **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**, **copayments** 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	---None---
	Specialist visit	20% coinsurance	50% coinsurance	---None---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Chiropractic services- up to 15 visits/plan year, combined In/Out-of-Network. MinuteClinic non-preventive visits – Member is responsible for the full cost (negotiated rate of \$45) while in deductible phase; after deductible is met, no charge.
	Preventive care screening/immunization	No Charge	Not Covered	Certain women's preventive services, obesity screenings and counseling for weight management and tobacco use are covered at no cost to member, In-network. For a full list of these services and/or prescriptions, contact Customer Service. Age and frequency schedules may apply to certain preventive services; see your plan document (SPD) for details.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Preventive x-ray and blood work are covered at no charge, In-Network.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network provider.

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

# CVS Health: BCBS IL Health Savings Plan 3

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage for: Individual + Family | Plan Type: HDHP

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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> or by calling Caremark Customer Care at (866) 284-9226</p>	Generic drugs: 30 day supply 90 day supply	20% coinsurance	Not Covered	Deductible waived for preventive medications. <u>There is no charge for:</u> <ul style="list-style-type: none"> <li>• generic preventive medications on the HSP Preventive Therapy Drug List</li> <li>• generic and preferred brand oral contraceptives</li> <li>• brand insulin on the HSP Preventive Therapy Drug List</li> </ul> In-network. Infertility medications have a lifetime maximum of \$10,000. Erectile Dysfunction medications limited to 6 pills/month. Maintenance medications must be filled as a 90 day supply at a CVS/pharmacy or through CVS Caremark Mail Order Pharmacy after two initial 30 day supplies are filled. There are some formulary exclusions. Over-the-counter medications & equipment are excluded. 30-day supply available through CVS Caremark Specialty Pharmacy only. You pay full discounted cost of the medication until you meet your deductible.
	Preferred brand drugs: 30 day supply 90 day supply	20% coinsurance	Not Covered	
	Non-Preferred brand drugs: 30 day supply 90 day supply	20% coinsurance	Not Covered	
	Specialty drugs – 30 day supply only	\$100 copayment after deductible	Not Covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network provider.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	---None---

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

# CVS Health: BCBS IL Health Savings Plan 3

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage for: Individual + Family | Plan Type: HDHP

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	20% coinsurance	20% coinsurance	\$500 non-notification penalty for Out-of-Network provider. No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transportation that is not approved is not covered.
	Urgent care	20% coinsurance	20% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network provider.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	LifeScope For You EAP provides unlimited phone consults and up to 6 free in-person outpatient counseling sessions per member / issue/year with no prior authorization. Contact Life Scope for You EAP at 800-789-8990 or email: <a href="mailto:Help@4healthcare.com">Help@4healthcare.com</a>
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network provider.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	---None---
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network provider.
If you are pregnant	Prenatal and postnatal care	Prenatal - No Charge Postnatal- 20% coinsurance	50% coinsurance	Lab and other tests during prenatal visit care may be subject to deductible and coinsurance.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Notification required for stays beyond 48 or 96 hours \$500 non-notification penalty for Out-of-Network provider

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

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
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	50% coinsurance	Up to 80 visits/plan, combined In/Out-of-Network; \$500 non-notification penalty for Out-of-Network.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical/Occupational therapy - Up to 60 visits/plan, combined In/Out-of-Network. Speech therapy – up to 40 visits/plan year, combined In/Out-of-Network.
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	20% coinsurance	50% coinsurance	Up to 120 visits/plan, combined In/Out-of-Network. \$500 non-notification penalty for Out-of-Network.
	Durable medical equipment	20% coinsurance	50% coinsurance	Replace every three years.
	Hospice service	20% coinsurance	50% coinsurance	\$500 non-notification penalty for Out-of-Network.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	---None--
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Formulary exclusions</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Long term care</li> <li>• Over-the-counter medications and equipment (unless otherwise noted)</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (Adult &amp; Child) (including glasses)</li> <li>• Routine foot care (except for diabetes)</li> <li>• Weight loss programs</li> </ul>

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.



## Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Bariatric surgery (one per lifetime: pre certification required: must use Blue Care Center of Distinction. See plan documents for details.)
- Chiropractic care (limited to 15 visits/plan year)
- Infertility treatment (\$10,000 lifetime maximum benefit; combined In/Out-of-Network for certain infertility services, provided requirements are met. Additional lifetime maximum benefit of \$10,000 for infertility medications. See plan documents for details.)
- Most coverage provided outside the U.S. See [www.bcbsil.com/CVS](http://www.bcbsil.com/CVS)
- Non-emergency care when traveling outside the U.S.

## 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 1-888-775-6481. 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](http://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](http://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 Blue Cross Blue Shield of Illinois at 1-888-775-6481 or visit [www.bcbsil.com](http://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](http://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 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.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-775-6481.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-775-6481

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-775-6481.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-775-6481.

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

**Questions:** Call 1-888-775-6481 or visit us at [www.bcbsil.com/cvs](http://www.bcbsil.com/cvs). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

## 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 \$3,530
- Patient pays \$4,010

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$860
Limits or exclusions	\$150
<b>Total</b>	<b>\$4,010</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$1,870
- Patient pays \$3,530

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$450
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,530</b>

Note: These examples are based on individual coverage only.

## 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**, **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.