



Blue Cross Blue Shield of Illinois
A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Lincolnway Area Affiliation of Participating School Districts: Option#4 Plan Coverage for: Individual / Family | Plan Type: HMO



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, call 1-800-892-2803 or at <https://policy-srv.box.com/s/6wp2lhou1kq6uptb9cxfg4fpcugv9>.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 Individual / \$1,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> , services that charge a <u>copayment</u> , and emergency room services are covered before you meet your <u>deductible</u> .	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$2,500 Individual / \$5,000 Family	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 <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-892-2803 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35/visit; <u>deductible</u> does not apply	Not Covered	Services or supplies that are not ordered by your <u>Primary Care Physician</u> or Women's Principal Health Care <u>Provider</u> , except emergency and routine vision exams, are not covered.
	<u>Specialist</u> visit	\$55/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	

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*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/6wp2tlhou1kq6upttb9cxfq4fpncugv9>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsil.com	Generic drugs	\$10/prescription (retail) \$30/prescription (mail order)	Not Covered	34-day supply at Retail 90-day supply at Mail Order
	Preferred brand drugs	\$50/prescription (retail) \$150/prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs.
	Non-preferred brand drugs	\$100/prescription (retail) \$300/prescription (mail order)	Not Covered	Certain women's <u>preventive services</u> will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	<u>Specialty drugs</u>	\$100/prescription (retail)	Not Covered	The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained from a Participating Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500/visit	Not Covered	<u>Specialty drug</u> coverage based on group policy. Prior authorization may be required. <u>Specialty retail</u> limited to a 30-day supply.
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.
If you need immediate medical attention	<u>Emergency room care</u>	\$150/visit plus 20% coinsurance; <u>deductible</u> does not apply	\$150/visit plus 20% coinsurance; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ground transportation only.
	<u>Urgent Care</u>	\$35/visit; <u>deductible</u> 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)	\$150/day plus 20% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. \$150 <u>copayment</u> for the 1st 9 days per calendar year.
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit; <u>deductible</u> does not apply	Not Covered	Unlimited visits. <u>Referral</u> required.
	Inpatient services	\$150/day plus 20% <u>coinsurance</u>	Not Covered	Unlimited days. <u>Referral</u> required. \$150 <u>copayment</u> for the 1st 9 days per calendar year.
If you are pregnant	Office visits	\$35 PCP/\$55 SPC/visit; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies for the 1st prenatal visit only.
	Childbirth/delivery professional services	No Charge	Not Covered	Cost sharing does not apply for <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$150/day plus 20% <u>coinsurance</u>	Not Covered	<u>Referral</u> may be required. \$150 <u>copayment</u> for the 1st 9 days per calendar year.
	<u>Home health care</u>	No Charge	Not Covered	<u>Referral</u> required.
	<u>Rehabilitation services</u>	\$100/visit; <u>deductible</u> does not apply	Not Covered	60 visits combined for all therapies
	<u>Habilitation services</u>	\$100/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	\$150/day plus 20% <u>coinsurance</u>	Not Covered	Excludes custodial care. <u>Referral</u> required.
	<u>Durable medical equipment</u>	No Charge	Not Covered	<u>Referral</u> required. Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	Inpatient <u>copayment</u> may apply. <u>Referral</u> required.
	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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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.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Custodial care• Dental care (Adult) | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Weight loss programs |
|--|---|---|

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

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Bariatric surgery• Chiropractic care• Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) | <ul style="list-style-type: none">• Hearing aids (for children 1 per ear every 24 months, for adults up to \$2,500 per ear every 24 months)• Infertility treatment (the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered)• Most coverage provided outside the United States. See www.bcbsil.com | <ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care (only in connection with diabetes) |
|--|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at 1-877-527-9431 or visit <http://insurance.illinois.gov>.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? 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): Para obtener asistencia en Español, llame al 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-2803.

To see examples of how [this plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist copayment \$55
- Hospital (facility) copayment \$150
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

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

- The plan's overall deductible \$500
- Specialist copayment \$55
- Hospital (facility) copayment \$150
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,640

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

- The plan's overall deductible \$500
- Specialist copayment \$55
- Hospital (facility) copayment \$150
- Other coinsurance 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

Health care coverage is important for everyone.	
We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.	
To receive language or communication assistance free of charge, please call us at 855-710-6984.	
If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.	
Office of Civil Rights Coordinator 300 E. Randolph St. 35th Floor Chicago, Illinois 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960
You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:	
U.S. Dept. of Health & Human Services 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



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If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعدك، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرقم 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。請撥電話 號碼 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, appelez 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 Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એ સહાયતા, એમ. કાચકમ બાબતે પૂછો હોય, તો તમને લેના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાવિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में नि:शुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 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 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. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ní, éí doodagoo la'da biká anánilwo'ígíí, na'ídlíkídigo, ts'ída bee ná ahóótí'í' t'áá nílk'e níká a' doolwoł dóó bina'ídlíkídígíí bee nílk' h odoonih. Áta'dahalne'ígíí bich'í' hodílnih kwe'e 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، یا شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jesli Ty lub osoba, ktorej pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezplatnej informacji i pomocy we własnym języku. Aby porozmawiac z tłumaczem, 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 связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش دے تو، آپ کو اپنی زبان میں ہندسند اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.