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.gbophb.org (click on HealthFlex/WebMD) or by calling 1-800-851-2201. If this summary and the plan document conflict, the plan document will control. **Medical coverage is provided by Blue Cross and Blue Shield of Illinois (BCBSIL), prescription coverage is provided by Express Scripts and behavioral health benefits are provided by United Behavioral Health (UBH).**

Your plan sponsor provided a medical expense reimbursement arrangement for 2013, called a health reimbursement account (HRA), that you can use to pay for eligible unreimbursed expenses, e.g., your deductible, co-payments and coinsurance described below. Your plan sponsor contributed a one-time amount of $300 into an HRA if you enrolled in HealthFlex on January 1, 2013. If you do not spend all the funds in your HRA during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**If took HealthQuotient:** $500 Individual/$1,000 Family **If did not take HealthQuotient:** $750 Individual/$1,250 Family (children only)/$1,500 Family (spouse or spouse & children) Doesn't apply to preventive care or routine newborn services. Copayments don't apply toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For pharmacy benefits, $2,000 Individual/$4,000 Family. The plan has no **out-of-pocket limit** for medical expenses.	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?	Premium, medical expenses and pharmacy expenses 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 starting 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	Yes. For a list of **participating providers**, see	If you use an **in-network** doctor or other health care

network of providers?	www.bcbsil.com or call 1-866-804-0976.	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 don't need a referral to see a specialist.	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 plan 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 **participating 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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit after deductible	Not covered	——————none——————
	Specialist visit	$50 copay/visit after deductible; no charge for allergy injections	Not covered	——————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
	Other practitioner office visit	After deductible, $30 copay/visit for chiropractor and $50 copay for naprapathy, acupuncture and massage therapy	Not covered	Combined coverage is limited to $1,000 annual maximum.
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	After deductible, $30 copay if primary care physician; $50 co-pay if specialist; no charge if hospital or independent lab	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs	**Retail (30-day)** $12 copayment	**Retail (30-day)** Copayment plus amount exceeding allowed amount	*To maximize Plan benefits, **refills for most maintenance medications will require fulfillment through the mail order pharmacy program**.
		***Mail Order (up to 90-day supply)** $20 copayment		
	Preferred brand drugs	**Retail (30-day)** 20% copayment $15 minimum; $45 maximum	**Retail (30-day)** Copayment plus amount exceeding allowed amount	*To maximize Plan benefits, **refills for**
		***Mail Order (up to 90-day supply)** 20% copayment ($40 min; $120 max)		

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
More information about **prescription drug coverage** is available at www.gbophb.org-click on HealthFlex/WebMD.	Non-preferred brand drugs	**Retail (30-day)** 25% copayment $30 minimum; $90 maximum	**Retail (30-day)** Copayment plus amount exceeding allowed amount	**most maintenance medications will require fulfillment through the mail order pharmacy program**. Non-sedating allergy drugs are covered as non-preferred. Specialty drugs may require pre-authorization by contacting Express Scripts at 1-800-841-2806.
		***Mail Order (up to 90-day supply)** 25% copayment ($75 min; $225 max)		
	Specialty drugs	Copayment dependent on classification of drug (e.g., preferred, non-preferred)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay per admission after deductible	Not covered	——————none——————
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$200 copay/visit		Notification required within 48 hours if admitted; copayment not applicable if admitted.
	Emergency medical transportation	No charge		
	Urgent care	$100 copay/visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay after deductible (waived if readmitted within 30 days for same condition)	Not covered	Pre-notification required. Verify with physician.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs To receive full benefits, contact UBH at 1-800-788-5614 for pre-authorization.	Mental/Behavioral health outpatient services	$15 copayment	40% coinsurance	Eligible out-of-pocket expenses for both the behavioral health and medical plans count toward the out-of-pocket maximum. Refer to page 1 for the applicable out-of-pocket maximum. In certain circumstances your out-of-pocket maximum may be lower.
	Mental/Behavioral health inpatient services	No charge	$300 copay then 40% coinsurance	
	Substance use disorder outpatient services	$15 copayment	40% coinsurance	
	Substance use disorder inpatient services	No charge	$300 copay then 40% coinsurance	
If you are pregnant	Prenatal and postnatal care	$30 copayment for initial visit	Not covered	Pre-notification required. Verify with physician.

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	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Coverage is limited to 60 visits per calendar year. Pre-notification required. Verify with physician.
	Rehabilitation services	$30 copay after deductible	Not covered	Physical/occupational therapy: combined $6,000 annual maximum. Speech therapy: $4,000 annual maximum.
	Habilitation services	$30 copay after deductible	Not covered	
	Skilled nursing care	No charge after deductible	Not covered	Coverage is limited to 120 days per calendar year. Pre-notification required. Verify with physician.
	Durable medical equipment	No charge after deductible	Not covered	Calendar Year maximum: $10,000 (excludes life sustaining equipment)
	Hospice service	No charge after deductible	Not covered	Pre-notification required. Verify with physician.
If your child needs dental or eye care	Eye exam	$20 copayment	Exam fee exceeding $50	Includes one exam every 12 months.
	Glasses	Not covered	Not covered	——————none——————
	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.)

- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Dental Care (Adult)
- Long-term Care

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.)

- Acupuncture
- Bariatric Surgery (in some cases)
- Chiropractic care
- Hearing Aids
- Infertility Treatment
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight-loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State law 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 1-866-804-0976. 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 the plan at 1-866-804-0976.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-851-2201.

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** $6,800
- **Patient pays** $740

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	$500
Copays	$40
Coinsurance	$0
Limits or exclusions	$200
Total	**$740**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information please contact: 1-866-804-0976.

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,200
- **Patient pays** $2,200

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	$500
Copays	$1,600
Coinsurance	$0
Limits or exclusions	$100
Total	**$2,200**

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.
- These examples assume the patient has met all requirements for any wellness incentives that may impact expenses.

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.

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