

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 has 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?	<p>If took HealthQuotient: For participating provider, \$500 Individual/\$1,000 Family For non-participating provider, \$1,000 Individual/\$2,000 Family</p> <p>If did not take HealthQuotient: For participating provider, \$750 Individual/\$1,250 Family (children only)/\$1,500 Family (spouse or spouse & children) For non-participating provider, \$1,250 Individual/\$2,250 Family (children only)/\$2,500 Family (spouse or spouse & children)</p> <p>Doesn't apply to preventive care or routine newborn services. Copayments don't apply toward the deductible.</p>	<p>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 3 for how much you pay for covered services after you meet the deductible.</p>
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 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	<p>Yes. For participating provider, \$3,000 Individual/\$6,000 Family For non-participating provider, \$6,000 Individual/\$12,000 Family For pharmacy benefits, \$2,000 Individual/\$4,000 Family</p>	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, balance-billed charges, non-participating hospital admission copayments, prescription drugs and health care this plan doesn't cover are not included in the medical out-of-pocket limit .	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Questions: Call 1-866-804-0976 or visit us at www.bcbsil.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-851-2201 to request a copy.

HealthFlex: Blue Cross and Blue Shield of Illinois

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

Coverage Period: 01/01/2013-12/31/2013

Plan Type: PPO B500 P1

	Prescription drugs are included in the pharmacy out-of-pocket limit .	
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers , see www.bcbsil.com or call 1-866-804-0976.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network . See the chart starting on page 3 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.

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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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	40% after deductible	—————none—————
	Specialist visit	\$50 copay/visit and 100% coverage for allergy injections	40% after deductible	—————none—————
	Other practitioner office visit	\$30 copay/visit for chiropractor and 50% coinsurance for naprapathy, acupuncture and massage therapy	50% coinsurance for chiropractor naprapathy, acupuncture and massage therapy	Coverage is limited to \$1,000 annual max.
	Preventive care/screening/immunization	No charge	No charge; 40% coinsurance after deductible for colonoscopy.	Non-participating provider benefit limited to \$100 annual max for services other than colonoscopy.
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	40% after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	—————none—————
If you need drugs to treat your illness or condition	Generic drugs	Retail (30-day) \$12 copayment	Retail (30-day) Copayment plus amount in excess of allowed amount	*To maximize plan benefits, <u>refills for most maintenance medications require use of the mail order pharmacy program.</u>
		*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 in excess of allowed amount		

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More information about prescription drug coverage is available at www.gbophb.org -- click on HealthFlex/WebMD.		*Mail Order (up to 90-day supply) 20% copayment (\$40 min; \$120 max)		Non-sedating allergy drugs are covered as non-preferred. Specialty drugs may require pre-authorization by contacting Express Scripts at 1-800-841-2806.
	Non-preferred brand drugs	Retail (30-day) 25% copayment \$30 minimum; \$90 maximum	Retail (30-day) Copayment plus amount in excess of allowed amount	
		*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)	20% after deductible	40% after deductible	_____none_____
	Physician/surgeon fees			_____none_____
If you need immediate medical attention	Emergency room services	\$200 copayment/visit		Notification required within 48 hours if admitted; copayment not applicable if admitted.
	Emergency medical transportation	20% after deductible		
	Urgent care	\$100 copayment/visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	\$200/admission and 40% coinsurance after deductible	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	30% 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	10% coinsurance	\$200 copay then 30% coinsurance	
	Substance use disorder outpatient services	\$15 copayment	30% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	\$200 copay then 30% coinsurance	
If you are pregnant	Prenatal and postnatal care	\$30 copayment for initial visit and 20% coinsurance after initial visit after deductible	40% coinsurance after deductible	Pre-notification required. Verify with physician.

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	Delivery and all inpatient services	20% coinsurance after deductible	40% after deductible	
If you need help recovering or have other special health needs	Home health care	20% after deductible	40% after deductible	Coverage is limited to 60 visits per calendar year. Pre-notification required. Verify with physician.
	Rehabilitation services	\$30 copayment	40% after deductible	Physical and occupational therapy: combined \$6,000 calendar year maximum. Speech therapy: \$4,000 calendar year maximum.
	Habilitation services	\$30 copayment	40% after deductible	
	Skilled nursing care	20% after deductible	40% after deductible	Coverage is limited to 120 days per calendar year. Pre-notification required. Verify with physician.
	Durable medical equipment	20% after deductible	40% after deductible	Calendar year maximum: \$10,000 (excludes life sustaining equipment)
	Hospice service	20% after deductible	40% after deductible	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	—————none—————	—————none—————	—————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 <u>excluded services</u> .)	
<ul style="list-style-type: none"> • Cosmetic Surgery • Long-term Care 	<ul style="list-style-type: none"> • Dental Care (Adult) • Non-emergency care when traveling outside the U.S.

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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
- Hearing Aids
- Routine eye care (Adult)
- Bariatric Surgery (in some cases)
- Infertility Treatment
- Routine foot care
- Chiropractic Care
- Private duty nursing
- 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.

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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 \$5,400
- Patient pays \$2,140

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	\$1400
Limits or exclusions	\$200
Total	\$2,140

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 \$3,260
- Patient pays \$2,140

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	\$40
Total	\$2,140

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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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