

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period:** 01/01/2024 – 12/31/2024

 BlueCross BlueShield of Illinois : **BlueCare Direct Bronze<sup>SM</sup> 401 with Advocate – Rx Copays**

**Coverage for:** Individual/Family | **Plan Type:** HMO

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company



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

[www.bcbsil.com/bb/ind/bb\\_bhsa01bhdiiip\\_il\\_2024.pdf](http://www.bcbsil.com/bb/ind/bb_bhsa01bhdiiip_il_2024.pdf) or by calling 1-800-892-2803. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
<b>Are there services covered before you meet your deductible?</b>	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Individual: Participating \$9,450 Family: Participating \$18,900	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com/bluecaredirect">www.bcbsil.com/bluecaredirect</a> or call 1-800-892-2803 for a list of Participating Providers.	This plan 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 <u>out-of-network 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 plan pays ( <u>balance billing</u> ). 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.
<b>Do you need a referral to see a specialist?</b>	Yes.	This plan 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$150/visit	Not Covered	None
	Specialist visit	\$160/visit	Not Covered	Referral required.
	Preventive care/screening/immunization	No Charge	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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$250/test	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	\$450/test	Not Covered	Referral required.

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\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com/bb/ind/bb\\_bhsa01bhdilp\\_il\\_2024.pdf](http://www.bcbsil.com/bb/ind/bb_bhsa01bhdilp_il_2024.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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsil.com/rx24h/6T">www.bcbsil.com/rx24h/6T</a>	Generic drugs (Preferred)	Retail - \$100/prescription Mail - \$300/prescription	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. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. 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. Any differences between the cost of the generic drug and the cost of the brand name drug will apply to the deductible or out-of-pocket maximum. The applicable cost sharing (by tier) and the cost difference between the generic and brand will never exceed the overall cost of the drug. 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.
	Generic drugs (Non-Preferred)	Retail - \$110/prescription Mail - \$330/prescription	Not Covered	
	Brand drugs (Preferred)	Retail - \$120/prescription Mail - \$360/prescription	Not Covered	
	Brand drugs (Non-Preferred)	Retail - \$175/prescription Mail - \$525/prescription	Not Covered	
	<u>Specialty drugs</u> (Preferred)	\$275/prescription	Not Covered	
	<u>Specialty drugs</u> (Non-Preferred)	\$500/prescription	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$750/visit plus 50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	\$400/visit	Not Covered	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$2,000/visit plus 50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	Per occurrence <u>copayment</u> waived upon inpatient admission.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$160/visit	Not Covered	Must be affiliated with member's chosen medical group or <u>referral</u> required.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500/day plus 50% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$150/office visit; 50% <u>coinsurance</u> for other outpatient services	Not Covered	Referral may be required. Telepsychiatry benefits are available; see your benefit booklet* for details.
	Inpatient services	\$1,500/day plus 50% <u>coinsurance</u>	Not Covered	Referral required.
<b>If you are pregnant</b>	Office visits	Primary Care: \$150 Specialist: \$160	Not Covered	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$1,500/day plus 50% <u>coinsurance</u>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	Not Covered	Referral required.
	<u>Rehabilitation services</u>	\$150/visit	Not Covered	Referral required.
	<u>Habilitation services</u>	\$150/visit	Not Covered	Referral required.
	<u>Skilled nursing care</u>	\$800/day	Not Covered	Referral required.
	<u>Durable medical equipment</u>	No Charge	Not Covered	Referral required.
	<u>Hospice services</u>	50% <u>coinsurance</u>	Not Covered	Referral required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	One visit per year. See your benefit booklet* for details.
	Children's glasses	No Charge	Not Covered	One pair of glasses per year up to age 19. See your benefit booklet* for details.
	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"><li>• Acupuncture</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Weight loss programs</li></ul>
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"><li>• Abortion care</li><li>• Bariatric surgery</li><li>• Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year)</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery (only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)</li><li>• Hearing aids (for children 1 per ear every 24 months, for adults up to \$2,500 per ear every 24 months)</li><li>• Infertility treatment (covered for 4 procedures per benefit period)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (with the exception of inpatient private-duty nursing)</li><li>• Routine eye care (Adult, 1 visit per benefit period)</li><li>• Routine foot care (when <u>medically necessary</u>)</li></ul>

**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. 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](http://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 on how 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](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 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? **Not Applicable**

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): Dinek'ehgo 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.*

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**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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)		<b>Managing Joe's Type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)		<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)																																											
■ <b>The plan's overall deductible</b>	\$0	■ <b>The plan's overall deductible</b>	\$0	■ <b>The plan's overall deductible</b>	\$0																																										
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■ <b>Other coinsurance</b>	50%	■ <b>Other coinsurance</b>	50%	■ <b>Other coinsurance</b>	50%																																										
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )																																											
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>																																										
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The plan would be responsible for the other costs of these EXAMPLE covered services.

**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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35 <sup>th</sup> Floor	Fax:	855-661-6960
Chicago, Illinois 60601		

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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	<a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>
Washington, DC 20201	Complaint Forms:	<a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>

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 تساعد أسئلة، فليك 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 તેવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા 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 निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक से बात करन 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 ni, éí doodago la'da biká anánílwo'ígíí, na'idílkidgo, ts'ida bee ná ahóótí'í' t'áá níik'e níká a'doolwoł dóó bina'idílkidgíí bee níh odoonih. Ata'dahalne'ígíí bich'í' hodiilnih kwe'é 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 شفاف، با شماره 855-710-6984 تماس حاصل نمایید.
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 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 کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں چندمتدد 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.