This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wespath.org (click on HealthFlex/WebMD, log in and click on HealthFlex Plan Benefits) or call **1-800-851-2201**. For general definitions of common terms, such as **allowed amount**, **balance billing,** **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms, see the **Glossary**. You can view the Glossary at **www.wespath.org** (click on HealthFlex/WebMD, log in and click on HealthFlex Plan Benefits) or call **1-800-851-2201** to request a copy. If this summary and the complete terms of coverage conflict, the complete terms of coverage will control.

Medical coverage is provided by Blue Cross and Blue Shield of Illinois (BCBSIL) (Phone: 1-866-804-0976); prescription coverage is provided by OptumRx (Phone: 1-855-239-8471); and behavioral health benefits are provided by United Behavioral Health (UBH) (Phone: 1-800-788-5614).

Your plan sponsor provides a medical expense savings account, called a health savings account (HSA), that you can use to pay for eligible unreimbursed expenses, e.g., your deductible, co-payments and coinsurance described below. This year your HSA will be funded with $750 for an individual or $1,500 for an individual with at least one covered dependent. If you do not spend all the funds in your HSA 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:** For participating provider, $1,500 Individual/$3,000 Family For non-participating provider, $2,500 Individual/$5,000 Family **If did not take HealthQuotient:** For participating provider, $1,750 Individual/$3,500 Family For non-participating provider, $2,750 Individual/$5,500 Family **Pharmacy and medical deductible is combined.** 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 1). 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 participating provider, $6,000 Individual/$12,000 Family For non-participating provider, $12,000 Individual $24,000 Family Limit includes medical, behavioral health and pharmacy. Other limits apply—see the chart that starts on page 2.	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, 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**.

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 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Other practitioner office visit	20% after deductible for chiropractor and 50% coinsurance for naprapathy, acupuncture and massage therapy	40% coinsurance after deductible for chiropractor; 50% coinsurance after deductible for naprapathy, acupuncture and massage therapy	Coverage for chiropractic, naprapathy, acupuncture and massage therapy is limited to 35 combined visits per calendar year.
	Preventive care/**screening**/immunization	No charge.	40% coinsurance.	——————none——————
If you have a test	**Diagnostic test** (X-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)			

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.wespath.org**; click on HealthFlex/WebMD.	Generic drugs	**Retail (30-day)** $15 copayment	**Retail (30-day)** Copayment plus amount exceeding allowed amount	*To maximize plan benefits, **refills for most maintenance medications require use of the mail order pharmacy program.** Non-preferred name brand drugs do not apply to the out-of-pocket limit. Non-sedating allergy drugs are covered as non-preferred. Specialty drugs may require pre-authorization by contacting OptumRx at **1-855-239-8471**. Must meet combined medical and pharmacy deductible before copayment applies.
		***Mail Order (up to 90-day supply)** $35 copayment		
	Preferred brand drugs	**Retail (30-day)** 25% copayment $25 minimum; $65 maximum	**Retail (30-day)** 25% copayment plus the amount in excess of the allowed amount	
		***Mail Order (90-day)** 25% copayment ($60 min; $150 max)		
	Non-preferred brand drugs	**Retail (30-day)** 30% copayment $50 minimum; $120 maximum	**Retail (30-day)** 30% copayment plus the amount in excess of the allowed amount	
		***Mail Order (up to 90-day supply)** 30% copayment ($95 min $260 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% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fees			——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible		Notification required within 48 hours if admitted; copayment not applicable if admitted. Costs assume true emergency.
	Emergency medical transportation	20% coinsurance after deductible		
	Urgent care	20% coinsurance after deductible		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	$200 copay and 40% coinsurance after deductible	Pre-notification required. Verify with physician.
	Physician/surgeon fees			

If you have mental health, behavioral health, or substance abuse needs For full benefits, contact UBH at **1-800-788-5614** for pre-authorization.	Mental/Behavioral health outpatient services	20% coinsurance after deductible	20% coinsurance after deductible for office visits*	** 40% coinsurance after deductible for all services other than office visits* Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward the out-of- pocket maximum. Refer to page 1 for the applicable out-of-pocket maximum.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	$200 copay then 40% coinsurance after deductible	
	Substance use disorder outpatient services	20% coinsurance after deductible	20% coinsurance after deductible for office visits*	
	Substance use disorder inpatient services	20% coinsurance after deductible	$200 copay then 40% coinsurance after deductible	
If you are pregnant	Prenatal and postnatal care	100% for prenatal care (except for ultrasounds) 20% coinsurance after deductible for ultrasounds and subsequent eligible physician charges	40% coinsurance after deductible	Pre-notification required. Verify with physician. Initial visit to confirm pregnancy subject to regular office visit copayment or coinsurance.
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	**Home health care**	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 60 visits per calendar year. Pre-notification required. Verify with
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 120 days per calendar year. Pre-notification required. Verify with
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Coverage for wigs is limited to 5 per lifetime.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-notification required. Verify with physician.

If your child needs dental or eye care	Eye exam	$20 copayment	Exam fee exceeding $45	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 is not a complete list. Check your policy or plan document for other excluded services.)	
• Cosmetic Surgery	• Dental Care (Adult)
• Long-term Care	• Non-emergency care when traveling outside the U.S.

Other Covered Services (This is not 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
• Private duty nursing	• Hearing Aids	• Infertility Treatment
	• Routine eye care (Adult)	• Routine foot care
		• Weight-loss programs

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at **1-866-804-0976** or contact: U.S. Department of Health & Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**. Other options to continue coverage are 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: 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 more information about your rights, this notice, or assistance, contact: the plan at **1-866-804-0976**.

Individual Responsibility: Yes. This coverage constitutes **minimum essential coverage** under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the **individual responsibility requirement**. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as "minimum value."

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 section.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Patient Pays" section for the same example under each plan's Summary of Benefits and Coverage.

This is not a cost estimator. Do not use these examples to estimate your actual costs under this **plan**. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Also, costs do not include **premiums** you pay to buy coverage under a plan.

Having a baby
(normal delivery)

- **Cost of care** $7,540
- **Plan pays** $4,820
- **Patient pays** $2,720

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	$1,500
Copayments	$20
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$2,720**

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

- **Cost of care** $5,400
- **Plan pays** $3,280
- **Patient pays** $2,120

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	$1,500
Copayments	$300
Coinsurance	$300
Limits or exclusions	$20
Total	**$2,120**