



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.wespath.org](http://www.wespath.org) (click on HealthFlex/WebMD, log in and click on My HealthFlex 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 underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) 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.

The plan sponsor provides 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 \$500 for an individual or \$1,000 for an individual with at least one covered dependent. If you do not use your entire HSA during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated funds.

Medical coverage and behavioral health benefits are provided by Blue Cross and Blue Shield of Illinois, Inc. (1-866-804-0976); and prescription coverage is provided by OptumRx (1-855-239-8471).

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>If took HealthQuotient:</b>                      For participating provider:                      \$2,000 Individual/\$4,000 Family                      For non-participating provider:                      \$3,000 Individual/\$6,000 Family</p> <p><b>If did not take HealthQuotient:</b>                      For participating provider:                      \$2,250 Individual/\$4,500 Family                      For non-participating provider:                      \$3,250 Individual/\$6,500 Family</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</p> <p>If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes, preventive care</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. \$50 Individual/\$150 Family for dental benefits, if elected.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these services.</p>

<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>For participating provider:</b> \$6,500 Individual/\$13,000 Family</p> <p><b>For non-participating provider:</b> \$13,000 Individual/\$26,000 Family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, the overall family <a href="#">out-of-pocket limit</a> must be met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Copayments</a> for certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, vision expenses, dental expenses, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call <b>1-866-804-0976</b> for a list of <a href="#">network providers</a>.</p>	<p>This plan uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your plan pays (<a href="#">balance billing</a>).</p> <p>Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	30% coinsurance after the deductible	50% coinsurance after the deductible	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.
	<a href="#">Specialist</a> visit	30% coinsurance after the deductible	50% coinsurance after the deductible	
	<a href="#">Preventive care/screening/immunization</a>	No charge.	50% coinsurance	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wespath.org">www.wespath.org</a> ; click on HealthFlex/WebMD.	Generic drugs	<b>Retail (30-day)</b> \$15 copayment after deductible	<b>Retail (30-day)</b> Copayment after deductible, plus amount exceeding allowed amount	*To maximize plan benefits, <b>refills for most maintenance medications require use of the OptumRx Home Delivery (mail-order) service or a local Walgreens pharmacy.</b>  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 <b>1-855-239-8471.</b>
		<b>*Mail Order (up to 90-day supply)</b> \$35 copayment after deductible		
	Preferred brand drugs	<b>Retail (30-day)</b> 25% coinsurance after deductible (\$25 minimum; \$65 maximum)	<b>Retail (30-day)</b> 25% coinsurance after deductible, plus amount exceeding allowed amount	
		<b>*Mail Order (up to 90-day supply)</b> 25% coinsurance after deductible (\$60 minimum; \$150 maximum)		
Non-preferred brand drugs	<b>Retail (30-day)</b> 30% coinsurance after deductible (\$50 minimum; \$120 maximum)	<b>Retail (30-day)</b> 30% coinsurance after deductible, plus amount exceeding allowed amount		

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)	
		<b>*Mail Order (up to 90-day supply)</b> 30% coinsurance after deductible (\$95 minimum; \$260 maximum)		
	<a href="#">Specialty drugs</a>	Coinsurance after deductible, dependent on classification of drug (e.g., preferred, non-preferred)	Coinsurance dependent on classification of drug (e.g., preferred, non-preferred)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% coinsurance after deductible	30% coinsurance after deductible	Notification required within 48 hours if admitted; copayment not applicable if admitted. Costs assume true emergency.
	<a href="#">Emergency medical transportation</a>	30% coinsurance after deductible	30% coinsurance after deductible	
	<a href="#">Urgent care</a>	30% coinsurance after deductible	30% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	\$200 copayment and 50% coinsurance after deductible	Pre-notification required. Verify with physician.
	Physician/surgeon fees	30% coinsurance after deductible	\$200 copayment and 50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	30% coinsurance after deductible for office visits*	Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward the out-of-pocket limit. Refer to page 1 or 2 for the applicable out-of-pocket limit.
	Inpatient services	30% coinsurance after deductible	\$200 copayment and 50% coinsurance after deductible	
If you are pregnant	Office visits	100% for prenatal care (except ultrasounds) 30% coinsurance after deductible for ultrasounds and subsequent eligible physician charges	50% coinsurance after deductible	<a href="#">Cost-sharing</a> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) Initial visit to confirm pregnancy subject to regular office visit co-payment or coinsurance.

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)	
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-notification required. Verify with physician.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% coinsurance after deductible	50% coinsurance after deductible	Coverage is limited to 60 visits per calendar year. Pre-notification required. Verify with physician.
	<a href="#">Rehabilitation services</a>	30% coinsurance after deductible	50% coinsurance after deductible	
	<a href="#">Habilitation services</a>	30% coinsurance after deductible	50% coinsurance after deductible	
	<a href="#">Skilled nursing care</a>	30% coinsurance after deductible	50% coinsurance after deductible	Coverage is limited to 120 days per calendar year. Pre-notification required. Verify with physician.
	<a href="#">Durable medical equipment</a>	30% coinsurance after deductible	50% coinsurance after deductible	Coverage for wigs is limited to 5 per lifetime.
	<a href="#">Hospice services</a>	30% coinsurance after deductible	50% coinsurance after deductible	Pre-notification required. Verify with physician.
If your child needs dental or eye care	Children's eye exam	<b>Exam Core:</b> \$20 copayment  <b>Full Vision:</b> \$20 copayment  <b>Premier Vision:</b> \$20 copayment	<b>Exam Core:</b> Exam fee exceeding \$45  <b>Full Vision:</b> Exam fee exceeding \$45  <b>Premier Vision:</b> Exam fee exceeding \$45	<b>Exam Core:</b> Includes one exam every year.  <b>Full Vision:</b> Includes one exam every year.  <b>Premier Vision:</b> Includes one exam every year.

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)	
	Children's glasses	<p><b>Exam Core:</b> Not Covered</p> <p><b>Full Service:</b> \$20 copayment for frames and/or lenses; for frames, 80% of cost in excess of \$160</p> <p><b>Premier Vision:</b> \$20 copayment for frames and lenses; for frames, 80% of cost in excess of \$200</p>	<p><b>Exam Core:</b> Not Covered</p> <p><b>Full Service:</b> Cost of frames in excess of \$70. Cost of single vision lenses over \$30; line bifocal lenses over \$50; lined trifocal lenses over \$65.</p> <p><b>Premier Vision:</b> Cost of frames in excess of \$70. Cost of single vision lenses over \$30; line bifocal lenses over \$50; lined trifocal lenses over \$65.</p>	<p><b>Exam Core:</b> None</p> <p><b>Full Service:</b> Includes one pair of frames every other year and lenses every year.</p> <p><b>Premier Vision:</b> Includes one pair of frames and lenses every year.</p>
	Children's dental check-up	<p><b>Dental PPO:</b> No charge</p> <p><b>Dental HMO:</b> No charge</p> <p><b>Passive PPO 2000:</b> No charge</p>	<p><b>Dental PPO:</b> No charge</p> <p><b>Dental HMO:</b> No charge</p> <p><b>Passive PPO 2000:</b> No charge</p>	<p><b>Dental PPO:</b> Annual coverage is limited to \$2,000 maximum (in-network) and \$1,000 (out-of-network) for all covered services</p> <p><b>Dental HMO:</b> Please refer to Dental HMO Patient Charge Schedule for additional services.</p> <p><b>Passive PPO 2000:</b> Coverage is limited to \$2,000 annual maximum for all covered services.</p>

### 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](#).)

- Cosmetic Surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture
- Dental care (Adult), if elected
- Private-duty nursing
- Weight loss programs
- Bariatric surgery (if meet eligibility)
- Hearing Aids
- Routine eye care (Adult)
- Chiropractic care
- Infertility Treatment
- Routine foot care

**Your Rights to Continue Coverage:** You may be eligible for continuation coverage through HealthFlex. Contact us at 1-800-851-2201 for more information. 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 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: 1-866-804-0976.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-800-851-2201.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-851-2201.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-851-2201.

HFE BCBSIL-HDHP H2000-P4-AII-AII-HSA500-1000/50402/9012019

-----*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist</a> coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,250
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$4,450</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist</a> coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$300
<b>The total Joe would pay is</b>	<b>\$2,800</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist</a> coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-851-2201.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.