

For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-892-2803 or at https://policy-srv.box.com/s/8z9bwxfoqfzgw5f2tv9whpgz3y4thndc.

All an	d costs shown in th	is chart are after your	has been met, if a	applies.
	Primary care visit to treat an injury or illness	\$30/visit	Not Covered	Services or supplies that are not ordered by your <u>Primary Care Physician</u> RU : RPH
<u>SURY</u> LGHU				

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called BCBSIL) *For more information about limitations and exceptions, see the <u>plan</u> or policy document at

Blue Cross and Blue Shield of Illinois, a Division of

https://policy-srv.box.com/s/8z9bwxfoqfzgw5f2tv9whpgz3y4thndc.

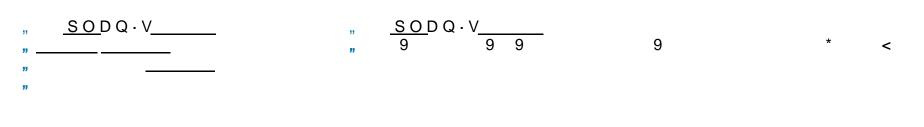
&KLOGUHQ¶V H	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.

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There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan Blue Cross and Blue Shield of Illinois at 1-

Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

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<u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Cost sharing					
Deductibles		\$0			
<u>oopayments</u>		\$100			
Coinsurance		\$0			
	/	FRY			
Limits or exclusions		\$60			

\$0

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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. 6984.





