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 _____ and _____ costs shown in this chart are after your _____ has been met, if a _____ applies.

S U R Y L G H U	Primary care visit to treat an injury or illness	$30/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician R U : R P H

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

	& K L O G U H Q ¶ V H	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.

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 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.

„ S O D Q · V_____ „ S O D Q · V_____

„ _____ _____ „

„ _____

„

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

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Cost sharing	
Deductibles	$0
[redacted]	$100
Coinsurance	$0
[redacted] F R Y	
Limits or exclusions	$60

The plan would be responsible for the other costs of these EXAMPLE covered services.

$0

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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.