Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the leas	Out-of-Network	

* For more information about limitations and exceptions, see the plan or policy document at

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the leas	Out-of-Network Provider (You will pay the most	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Virtual Visit 20% coinsurance/visit; deductible applies. See your benefit boo for details. Preauthorization may be required, see your benefit booklet* for details.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of serv a coinsurance or deductible may apply. Maternity care may inclup Td [(co)-3 7

* For more information about limitations and exceptions, see the plan or policy document at

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)		
Acupuncture	Long-term care	Weight loss programs
Dental care (Adult)	Routine foot care (with the exception of per with diagnosis of diabetes)	

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Bariatric surgery	Hearing aids (for children 1 per ear ever months for, adults up to $500 per ear every 60 months)	Non-emergency care when traveling outsi U.S.
Cosmetic surgery (only for correcting congé deformities or conditions resulting from accidental injuries, scars, tumors, or dis	Infertility Treatment	Private-duty nursing (with the exception of inpatient private duty nursing) (limited to 48 v
Chiropractic care (Chiropractic and Osteop manipulation limited to 30 visits per calendar year)	Most coverage provided outside the Uni States. See www.bcbsil.com	Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information fo agencies is: the plan at 1-888-6024 8 6 ' H S D U W P H Q W R I / D E R U ¶ V (P S O-866-444-EBSA (3272) or V 6 H F X U L W \ $ www.dol.gov/ebsa/healthreform (28 8974.4-d)-3 (o)-3 24ea.(458 F)]4 /r m<</M0 (h)-5 (e)-3 6.583 ( )]TJ -rg.584 yoob1 403.2ur cra

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 provider charge, and many other factors. Focus on cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan

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