Benefits Summary

Music Institute of Chicago | April 1, 2020

BETTER BUSINESS PLANNING INC.

Better benefits | Better people

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

M E DICAL:
Blue Cross Blue Shield of Illinois
PPO: 800-541-2767
HMO: 800-892-2803
www.bcbsil.com

DE NTA L:
Principal
800-247-4695
www.principal.com

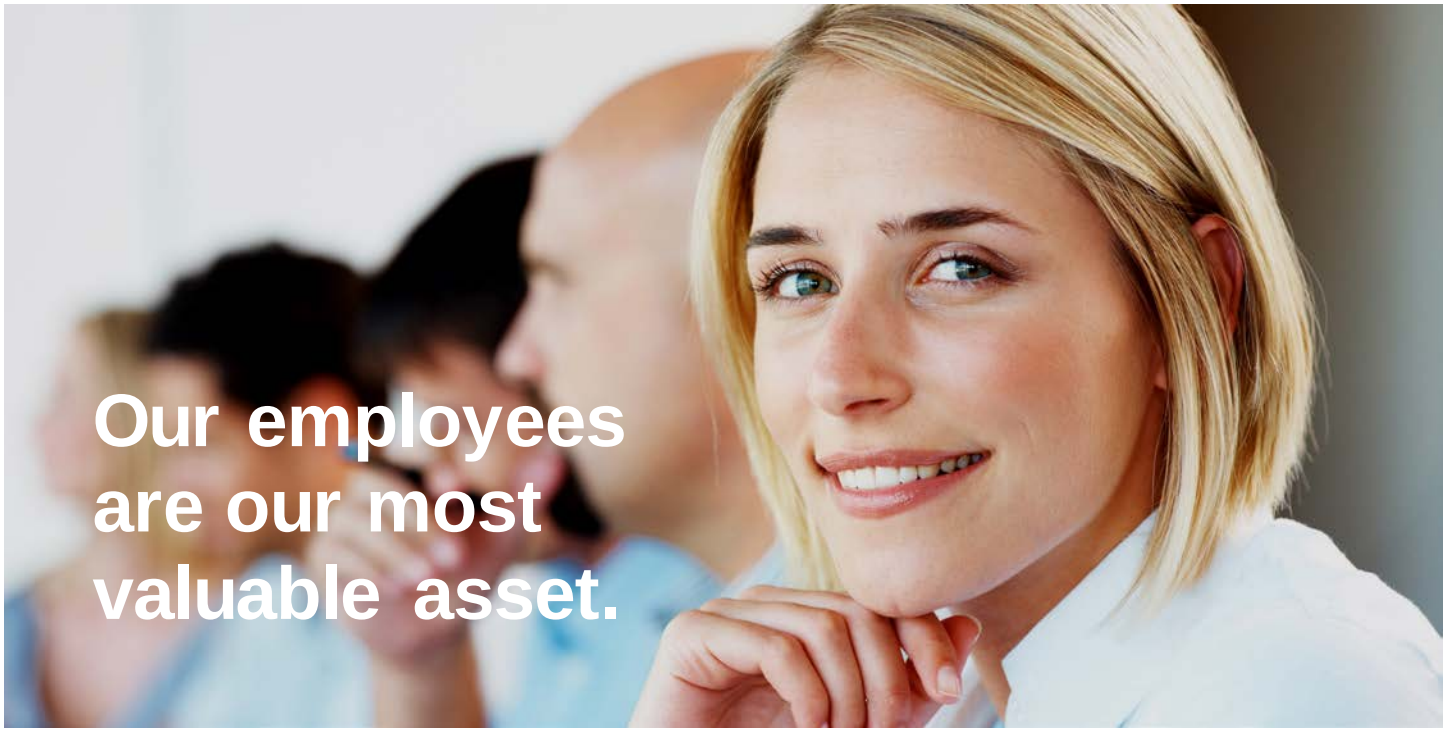
V IS IO N:
Eye Med
855-362-5539
www.eyemedvisioncare.com/bcbsilvis

L IF E /AD&D and VOLUNTARY LIFE:
BCBS of IL
800-367-6401
www.ancillaryquestionsil@bcbsil.com

VOLUNTARY SHORT TERM DISABILITY and LTD :
BCBS of IL
800-367-6401
www.disabilityclaimsil@bcbsil.com

FLEXIBLE SPENDING ACCO UN TS (F SA) :
Better Business Planning
630-773-2228
www.mywealthcareonline.com/bbp

Benefits Enrollment



That's why we at MIC are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.

Stay Healthy

- Medical, Dental and Vision Care
  (please remember that all HMO members must select a Primary Care Physician)
- Flexible Spending Accounts

Feeling Secure

- Short and Long Term Disability Insurance
- Basic Life and Accidental Death & Dismemberment
- Voluntary Life and Accidental Death & Dismemberment

Benefit Enrollment & Eligibility

BENEFIT	EFFECTIVE DATE
Medical	1st of the month following 30 days
Dental	1ST of the month following 30 days
Vision	1st of the month following 30 days
Life/AD&D	1ST of the month following 30 days
Voluntary Life/AD&D	1st of the month following 30 days
Voluntary Short Term Disability	1ST of the month following 30 days
Long Term Disability	1st of the month following 30 days
Flexible Spending Account (FSA)	1st of the month following 30 days

PLEASE NOTE:

MIC has retained all 6 of the current medical plans from BCBS.

MIC has retained the 2 current dental plans from Principal.

MIC continues to offer and pay 100% for Basic Life and Long Term Disability. However, these lines of coverage have been moved to BCBS of IL effective 4/1/20. Voluntary STD and Voluntary Life are also now with BCBS of IL.

MIC will continue to offer and pay 100% of the employee rate for Vision. The Vision coverage has been moved to BCBS of IL utilizing the Eye Med provider network.

Enclosed in this guide are details for all lines of coverage.

ENROLLING ONLINE

Enrolling in benefits is strictly online. To enroll, go to www.paylocity.com and log in with the user name and password that you created. (The MIC company code is 17634.) Paylocity should open to the Self-Service Portal, where you will begin the enrollment process from the "Manage my Benefits" link in the Benefits section. Human Resources will provide more detailed enrollment instructions.

Benefits Enrollment & Eligibility

Your initial benefit eligibility period is the only time of year outside of Open Enrollment that you can change your benefit selections without a qualified life event. It is extremely important that you review your benefits carefully and make sure you have selected the best options for you and/or your family.

OPEN ENROLLMENT PERIOD

Several weeks prior to the benefit plans' renewal date, eligible employees have the option of making changes to current benefit elections or selecting benefit coverage in any of the plans offered if coverage was previously waived. This time frame is known as the benefits Open Enrollment. **If your desire is to keep your same coverage, you do not have to re-enroll.** And if you previously waived coverage and that remains your desire, you also do not have to take any action. *However, if you are selecting benefits for the first time of if you make any changes to any plans, you are required to actively enroll.* Unless an employee experiences a "Qualifying Event" (explained below), Open Enrollment is the only time during the year that you may enroll or make changes to your coverage.

QUALIFYING EVENTS/SPECIAL ENROLLMENT

Certain "Qualifying Events" that occur throughout the year may allow you to make changes and/or add coverage previously waived. Please see the “Special Enrollment Provisions” under the “Important Notices” section regarding your opportunity to enroll in coverage for yourself and/or your dependents if certain events occur during the year.

DEPENDENT ELIGIBILITY CIRCUMSTANCES

As part of the federal Patient Protection and Affordable Care Act (more commonly known as Health Care Reform), dependents under the age of 26 — regardless of marital status — may be eligible for coverage under your employer sponsored health plan (medical, vision and/or dental benefits).

In addition, under Illinois law, any unmarried dependent child under 30 years of age is eligible for dependent coverage if the dependent meets all three (3) of the following conditions:

i. is an Illinois resident,
ii. served as an active or reserve member of any U.S. Armed Forces and
iii. received release or discharge other than dishonorable discharge

Enrollees must submit to the insurer a form approved by the Illinois Department of Veterans’ Affairs stating the date on which the dependent was released from service. Please note you may be required to pay for all or part of the cost of your dependent’s health care coverage.

The Illinois Religious Freedom Protection & Civil Union Act (Public Act 96-1513) affords same sex and opposite sex couples entering into a civil union the same obligations, responsibilities, protections, and benefits afforded or recognized by the law of Illinois to spouses. Under the Act, a person is a “party to a civil union” if they establish a civil union under a licensing process established by the Illinois Director of Public Health. Guidance published by the Cook County Clerk’s office recognizes health insurance in a list of benefits that a party to a civil union is entitled to under the law. The new law provides that a “party to a civil union” is to be included in any definition used in state law where the term “spouse”, “family”, or other terms that denote “spousal relationship” are stated.

Benefits Enrollment & Eligibility

NEW EMPLOYEE BENEFITS ENROLLMENT

New employees are eligible to enroll in the full benefit plan offerings upon hire. Benefits become effective the first of the month following 30 days of employment. Enrollment is online, via Paylocity. If a new employee does not enroll when initially eligible, they must wait until the next Open Enrollment to enroll in benefits, unless they experience a Qualifying Event.

REMINDER REGARDING MEDICARE ELIGIBILITY

We also would like to take this time to alert you to the fact that if you and/or your dependents become eligible for Medicare now or during the coming year, and you decide to elect Medicare as your primary insurance, you must alert the Human Resources Department at MIC and the health insurance carrier immediately. Group health plans must follow federal Medicare coordination rules and you and the insurance carrier may need to take action to avoid a disruption.

BlueCross BlueShield of Illinois

Understanding Your Coverage Options

with the Member Pay the Difference prescription drug benefit.

Through Blue Cross and Blue Shield of Illinois (BCBSIL), your prescription drug benefit uses a Member Pay the Difference pharmacy benefit designed to encourage members to use medicines that have been shown to be safe, and cost-effective.

How does Member Pay the Difference work?

When you fill a prescription through a contracting pharmacy* for a covered brand name drug where a **generic equivalent** is available, you may pay more. You will pay your brand copay/coinsurance amount ***plus*** the difference in cost between the brand drug and its generic equivalent.

This would apply even if your doctor writes "do not substitute" on your prescription. All prescription drug copay/coinsurance amounts, including member pay the difference costs, will count toward your total out-of-pocket costs.†

What is a generic drug?

A generic drug is a version of a brand name drug, and is also approved by the U.S. Food and Drug Administration (FDA). When compared to the brand drug, a generic drug is chemically the same, is as safe, and works just as well in the body for most people. But the generic drug often costs less.

There are two types of generics:

- A ***generic equivalent*** is made with the same active ingredient(s) at the same dose as the brand drug.
- A ***generic alternative*** is often used to treat the same condition, but the active ingredient(s) differs from the brand drug.

Your pharmacist can often substitute a generic equivalent for its brand counterpart without a new prescription from your doctor. But only you and your doctor can decide if a generic alternative is right for you. Please note that the Pay the Difference benefit does not apply to generic alternatives.

Get the most from your pharmacy benefit.

Consider using generic drugs, and follow these tips to help you get the most from your benefits:

- View the BCBSIL Prescription Drug List, also known as a formulary. Ask your doctor to check this list when recommending prescription drug options for you.
- Consider using the mail service program, which offers up to a 90-day supply of covered long-term (or maintenance) medicines.
- Use online pharmacy resources to get information about your out-of-pocket cost for a prescription, view your claims history and more.

Go to bcbsil.com and log in to Blue Access for Members℠ to learn more about your prescription drug benefit and access online resources.

What if I have questions?

Ask your doctor or pharmacist about the choices you have and which drug is right for you. Remember, treatment decisions are always between you and your doctor.

If you have any questions about your prescription drug benefit, see your plan materials or call the Pharmacy Program number on the back of your member ID card.

*The relationship between Blue Cross and Blue Shield of Illinois (BCBSIL) and contracting pharmacies is that of independent contractors, contracted through a related company, Prime Therapeutics LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

†Your out-of-pocket costs are determined by your particular benefit plan. Coverage is always subject to the exclusions and limitations of your benefit plan.

227151.1014

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-892-2803. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual: Participating $1,500 Family: Participating $3,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-892-2803 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not Covered	None
	Specialist visit	$40/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	No Charge	No Charge	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. You may be eligible to synchronize your prescription refills, please see your benefit booklet* for details.
	Non-preferred generic drugs	Retail - Preferred - $10/prescription Non-Preferred - $10/prescription Mail - $20/prescription	Not Covered	
	Preferred brand drugs	Retail - Preferred - $50/prescription Non-Preferred - $50/prescription Mail - $100/prescription	Not Covered	
	Non-preferred brand drugs	Retail - Preferred - $100/prescription Non-Preferred - $100/prescription Mail - $200/prescription	Not Covered	
	Preferred specialty drugs	$150/prescription	Not Covered	
	Non-preferred specialty drugs	$250/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	No Charge	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250/visit	$250/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	Primary Care: $20 Specialist: $40	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/office visits or No Charge for other outpatient services	Not Covered	Referral required.
	Inpatient services	No Charge	Not Covered	
If you are pregnant	Office visits	Primary Care: $20 Specialist: $40	Not Covered	Copayment applies to first prenatal visit per pregnancy. Referral required. Cost sharing does not apply for preventive services. Depending on the type of services, copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient copayment is charged in addition to the overall deductible.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	No Charge	Not Covered	Referral Required. 60 visits combined/ calendar year. Includes, but is not limited to, physical, occupational or speech therapy. Copayment may apply.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Referral required. Excludes custodial care.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Referral required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Limited to 1 hearing aid for each ear, every 36 months for members under the age of 18)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Routine eye care (Adult)
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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:

English (English): For assistance in English call 1-800-892-2803.
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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 plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$960**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-892-2803. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual: Participating $1,500 Family: Participating $3,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-892-2803 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider(You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Not Covered	None
	Specialist visit	$50/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	No Charge	No Charge	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. You may be eligible to synchronize your prescription refills, please see your benefit booklet* for details.
	Non-preferred generic drugs	Retail - Preferred - $10/prescription Non-Preferred - $10/prescription Mail - $20/prescription	Not Covered	
	Preferred brand drugs	Retail - Preferred - $50/prescription Non-Preferred - $50/prescription Mail - $100/prescription	Not Covered	
	Non-preferred brand drugs	Retail - Preferred - $100/prescription Non-Preferred - $100/prescription Mail - $200/prescription	Not Covered	
	Preferred specialty drugs	$150/prescription	Not Covered	
	Non-preferred specialty drugs	$250/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	No Charge	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider(You will pay the most)	
If you need immediate medical attention	Emergency room care	$250/visit	$250/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	Primary Care: $30/visit Specialist: $50/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/office visits or No Charge for other outpatient services	Not Covered	Referral required.
	Inpatient services	No Charge	Not Covered	
If you are pregnant	Office visits	Primary Care: $30 Specialist: $50	Not Covered	Copayment applies to first prenatal visit per pregnancy. Referral required. Cost sharing does not apply for preventive services. Depending on the type of services, copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	No Charge	Not Covered	Referral Required. 60 visits combined/ calendar year. Includes, but is not limited to, physical, occupational or speech therapy. Copayment may apply.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Referral required. Excludes custodial care.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Referral required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider(You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (1 hearing aid for each ear, every 36 months for members under the age of 18)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Routine eye care (Adult)
- Routine foot care (only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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:

English (English): For assistance in English call 1-800-892-2803.
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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 plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-541-2768. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating $1,000 Non-Participating $2,000 Family: Participating $3,000 Non-Participating $6,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Doesn't apply to certain preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. Individual: Participating $3,000 Non-Participating $6,000 Family: Participating $9,000 Non-Participating $18,000 Prescription Drug expense limit: $1,000 Individual $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com** or call **1-800-541-2768** for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	40% coinsurance	Acupuncture not covered.
	Specialist visit	$50 copayment/visit	40% coinsurance	none
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	$15/$30 copayment/ prescription	$15 copayment/ prescription	Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. For Non-Participating drug Provider you are responsible for 25% of the eligible amount after the copayment. RX Out-of-Pocket Expense Limit: $1,000 Individual/$3,000 Family. You may be eligible to synchronize your prescription refills, *please see your benefit booklet for details.
	Preferred brand drugs	$30/$60 copayment/ prescription	$30 copayment/ prescription	
	Non-preferred brand drugs	$50/$100 copayment/ prescription	$50 copayment/ prescription	
	Specialty drugs	Covered	Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300 copayment/visit plus 40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit or 20% coinsurance	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	none
If you are pregnant	Office visits	$30 copayment	40% coinsurance	Copayment applies to first prenatal visit per pregnancy.Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	none
	Childbirth/delivery facility services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	none
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	none
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	none
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)		
• Bariatric surgery • Chiropractic care • Hearing aids (Limited to 1 hearing aid for each ear, every 36 months for members under the age of 18)	• Infertility treatment (4 per benefit period) • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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 plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,210**

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

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-541-2768. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating $2,500 Non-Participating $5,000 Family: Participating $7,500 Non-Participating $15,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Doesn't apply to certain preventive care. Copays don't count toward the Deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. Individual: Participating $4,500 Non-Participating $9,000 Family: Participating $10,200 Non-Participating $20,400 Prescription Drug expense limit: $1,000 Individual $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com** or call **1-800-541-2768** for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	40% coinsurance	Virtual visits may be available, please refer to your policy for more details.
	Specialist visit	$50 copayment/visit	40% coinsurance	none
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 PCP/$50 SPC copayment/visit	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	$10/$15 copayment/ prescription	$15 copayment/ prescription	Lower Copayment applies to preferred participating pharmacies. Retail limited to 30 day supply. Mail order limited to 90 day supply at 2X copayment amount.Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. For Non-Participating drug Provider you are responsible for 25% of the eligible amount after the copayment. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. RX Out-of-Pocket Expense Limit: $1,000 Individual/$3,000 Family. You may be eligible to synchronize your prescription refills, *please see your benefit booklet for details.
	Preferred brand drugs	$40/$50 copayment/ prescription	$50 copayment/ prescription	
	Non-preferred brand drugs	$60/$70 copayment/ prescription	$70 copayment/ prescription	
	Specialty drugs	Covered	Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	20% coinsurance	40% coinsurance	copayment may apply.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300 copayment/visit plus 40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment for office visit or 20% coinsurance for other outpatient services	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. Virtual visits may be available for Outpatient services, please refer to your policy for more details.
	Inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	
If you are pregnant	Office visits	$30 copayment	40% coinsurance	Copayment applies to first prenatal visit per pregnancy.Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	none
	Childbirth/delivery facility services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	none
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	$300 copayment/visit plus 40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	none
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	none
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (30 visit max)
- Hearing aids (Limited to 1 hearing aid for each ear, every 36 months for members under the age of 18)
- Infertility treatment (4 per benefit period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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 plan's overall deductible	$2,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,660**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,660**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-541-2768. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating/ Non-Participating $2,500 Family: Participating/ Non-Participating $5,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Doesn't apply to certain preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. Individual: Participating/ Non-Participating $5,000 Family: Participating/ Non-Participating $10,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com** or call **1-800-541-2768** for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	20% coinsurance	Acupuncture not covered. Virtual visits may be available, please refer to your policy for more details.
	Specialist visit	No Charge	20% coinsurance	none
	Preventive care/screening/ immunization	No Charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	No Charge	No Charge	Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. Specialty retail/home delivery limited to 30 day supply. You may be eligible to synchronize your prescription refills, *please see your benefit booklet for details.
	Non-preferred generic drugs	No Charge	No Charge	
	Preferred brand drugs	No Charge	No Charge	
	Non-preferred brand drugs	No Charge	No Charge	
	Specialty drugs	No Charge	No Charge	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	none
	Physician/surgeon fees	No Charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	none
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	No Charge	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$300 copayment/visit plus 20% coinsurance	none
	Physician/surgeon fees	No Charge	20% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	20% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. Virtual visits may be available for Outpatient services, please refer to your policy for more details.
	Inpatient services	No Charge	$300 copayment/visit plus 20% coinsurance	none
If you are pregnant	Office visits	No Charge	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	20% coinsurance	none
	Childbirth/delivery facility services	No Charge	$300 copayment/visit plus 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	none
	Rehabilitation services	No Charge	20% coinsurance	
	Habilitation services	No Charge	20% coinsurance	
	Skilled nursing care	No Charge	$300 copayment/visit plus 20% coinsurance	
	Durable medical equipment	No Charge	20% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	20% coinsurance	none
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	none
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Limited to 1 hearing aid for each ear, every 36 months for members under the age of 18)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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 plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other	$0

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,560**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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.bcbsil.com/member/policy-forms/2019 or by calling 1-800-541-2768. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating $3,500 Non-Participating $7,000 Family: Participating $7,000 Non-Participating $14,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Out-of-network Inpatient $300. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. Individual: Participating $5,800 Non-Participating $17,400 Family: Participating $7,350 Non-Participating $22,050	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com** or call **1-800-541-2768** for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual Visits: 20% coinsurance. See your benefit booklet* for details.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	Preferred - 10% coinsurance Non-Preferred - 20% coinsurance	Retail - 20% coinsurance	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. You may be eligible to synchronize your prescription refills, please see your benefit booklet* for details.
	Non-preferred generic drugs	Preferred - 10% coinsurance Non-Preferred - 20% coinsurance	Retail -20% coinsurance	
	Preferred brand drugs	Preferred - 20% coinsurance Non-Preferred - 30% coinsurance	Retail - 30% coinsurance	
	Non-preferred brand drugs	Preferred - 30% coinsurance Non-Preferred - 40% coinsurance	Retail - 40% coinsurance	
	Preferred specialty drugs	40% coinsurance	40% coinsurance	
	Non-preferred specialty drugs	50% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300/visit plus 40% coinsurance	Preauthorization required. Preauthorization penalty: $1,000 or 50% of the eligible charge. See your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Outpatient: Preauthorization may be required; see your benefit booklet* for details. Inpatient: Preauthorization required.
	Inpatient services	20% coinsurance	$300/visit plus 40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$300/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	$300/visit plus 40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2019.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Limited to 30 visits per calendar year)
- Hearing aids (Limited to 1 hearing aid for each ear, every 36 months for members under the age of 18)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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 plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,260**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

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.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

MUSIC INSTITUTE of CHICAGO

Voluntary Dental PPO Benefit Summary

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Benefit Choice	Eligible members may select ONE OF THE TWO BENEFIT OPTIONS outlined below

Option 2 (Low Plan)

Benefits Payable				
Job Class	MBRS ELECT LOW DEN PLAN			
Network	Dental Preferred Provider Organization (PPO)			
Network Service Area	Includes the Illinois counties of Champaign, Coles, Cook, DeKalb, DeWitt, DuPage, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Jackson, Jefferson, Jersey, Kane, Kankakee, Kendall, Lake, Lee, Logan, Madison, Macoupin, McDonough, McHenry, McLean, Monroe, Montgomery, Morgan, Peoria, Perry, Sangamon, St. Clair, Tazewell, Union, Vermillion, Wayne, Whiteside, Will, Winnebago, Woodford.			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**
Unit 1 – Preventive	$0	$300	100%	10%
Unit 2 – Basic	$50	$300	80%	10%
Unit 3 – Major	$50	$300	50%	10%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effectives will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year.			

Emergency Services	If a member requires treatment or service for an emergency dental condition and cannot reach a preferred dental provider without unreasonable delay, benefits for such treatment or service received from a non-preferred dental provider will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that identifies the situation as an emergency.
Participating Provider Services	If a member requires treatment or service and cannot reasonably reach a preferred dental provider and the member receives such treatment or service from a non-preferred dental provider, benefits for such treatment or service received will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that informs Principal Life there was no participating provider reasonably available.

How Are Dental Procedures Covered Under Option 2?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Emergency exams – subject to Routine exam frequency limit • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months • Harmful Habit Appliance - covered only for dependent children under age 19 • Fillings and stainless steel crowns • Composite fillings on molars • Simple Oral Surgery • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Simple Endodontics (root canal therapy for anterior teeth)
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Periodontal Surgical Procedures – one each quadrant each 36 months • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Option 1 (High Plan)

Benefits Payable				
Job Class	MBRS ELECT HIGH DEN PLAN			
Network	Dental Preferred Provider Organization (PPO)			
Network Service Area	Includes the Illinois counties of Champaign, Coles, Cook, DeKalb, DeWitt, DuPage, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Jackson, Jefferson, Jersey, Kane, Kankakee, Kendall, Lake, Lee, Logan, Madison, Macoupin, McDonough, McHenry, McLean, Monroe, Montgomery, Morgan, Peoria, Perry, Sangamon, St. Clair, Tazewell, Union, Vermillion, Wayne, Whiteside, Will, Winnebago, Woodford.			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$0	$75	80%	80%
Unit 3 – Major	$50	$75	50%	50%
Family Deductible Maximum	2 times the per person deductible amount			
Combined Deductible	Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effectives will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year.			
Emergency Services	If a member requires treatment or service for an emergency dental condition and cannot reach a preferred dental provider without unreasonable delay, benefits for such treatment or service received from a non-preferred dental provider will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that identifies the situation as an emergency.			
Participating Provider Services	If a member requires treatment or service and cannot reasonably reach a preferred dental provider and the member receives such treatment or service from a non-preferred dental provider, benefits for such treatment or service received will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that informs Principal Life there was no participating provider reasonably available.			

How Are Dental Procedures Covered Under Option 1?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Emergency exams – subject to Routine exam frequency limit • Harmful Habit Appliance - covered only for dependent children under age 19 • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral • Fillings and stainless steel crowns
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Simple Oral Surgery • Complex Oral Surgical Procedures • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Periodontal Surgical Procedures – one each quadrant each 36 months • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup- each 120 per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse, qualified domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

An annual enrollment applies. Members can enroll for dental coverage during the annual enrollment period and not be subject to the late entrant waiting period. Certain restrictions apply.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

How Are Complaints Handled?

A “complaint” is a written communication primarily expressing a grievance and is filed by a consumer, a healthcare provider, or your representative either directly with Principal Life Insurance Company or via the Illinois Insurance Department. Complaints may be handwritten or typed and may be transmitted electronically, by facsimile, or by U.S. Mail.

Regulator complaints are first recorded by the corporate complaint register and forwarded to Group Life and Health Compliance for assignment to a complaint handler. Non-regulator complaints are handled by the Group Life & Health compliance department, the local claim service center, or the administration or underwriting department assigned to the consumer’s account.

Once a complaint is received, an acknowledgement letter is immediately sent identifying the name, address, and phone number of the person handling the complaint. An investigation is then made of the complaint. Within twenty-one (21) calendar days of the date of the Illinois Insurance Department's letter (or earlier, if specified by the Insurance Department), a substantive response is provided pursuant to instruction in the Illinois Insurance Department's cover letter. Within fifteen (15) working days from the receipt of a non-regulator complaint, a substantive response is provided to the complainant.

The response includes a description of how and when the consumer was covered with Principal Life, the policy provisions that govern the issues in question, what has transpired on the account, and an explanation of the decision either to uphold the original handling of the account or to take corrective action, why, and within what timing.

Principal Life maintains a complaint register that allows individual reconstruction of complaints as well as summary data.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
Late Entrant Provision	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

eService

Go online to check your benefits

Keeping track of your benefits has never been easier

When you want information about your benefits from Principal®, simply go online. Best of all, this service is available at no charge.

How to create an online account

It's easy! We'll have you up and running in no time.

1 | Go to **principal.com**.

2 | Select **Log In,** then **Personal.**

3 | After selecting **Create an account,** enter personal information such as your date of birth and identification number.

4 | **Create a username** and password, and provide an email address.

You'll receive an email within a few minutes to confirm your account is ready to go. You can access your account information anytime, 24/7, with the username and password you've just set.

Manage your benefits online

After logging in, you can manage your benefits, as well as other products you may have with Principal. Your online account allows you to:

- View and manage claims (for applicable benefits)
- Get a 24-month history of your explanation of benefits (EOB)
- Access your summary of benefits, as well as benefit booklets and policies
- Find a list of covered dependents
- View and print your dental ID card
- Find discounts and services
- Calculate coverage needs and more

Keeping your account safe

Your information is important to us. And because of that, we use a security feature that prevents others from accessing your account – even if they have your password. Verification codes add an extra layer of security. The first time you log in, you'll **need to choose where you want us to send the verification codes – either by text or email.**

If you log in from an unrecognized computer or mobile phone, forget your password, or we notice anything out of the ordinary, these codes help us confirm it's really you accessing your account – not someone pretending to be you.

You can choose to receive these codes every time you log in or only when we detect unusual activity.

Dental insurance

See the rewards of making healthy dental choices

Be prepared for big dental expenses with Maximum Accumulation

Like most of us, you know how important it is to take care of your teeth by getting regular dental check-ups. Preventive care can help you avoid the big stuff when it comes to your teeth. But it's not foolproof.

What happens when your dentist delivers the news that you need costly dental procedures? Dental insurance can be a big help financially, but there's a limit on how much it'll pay each calendar year. It's called your maximum benefit.

That's where Maximum Accumulation comes in.

How does Maximum Accumulation work?

You likely won't use all your maximum benefit every year. So where does that money go? If you visit your dentist during the year, you may be eligible to roll over a portion of your unused maximum benefit to increase your maximum benefit for the following year. It's available when you have dental coverage for preventive, basic and major services.

- **Preventive —** Exams, cleanings and sometimes x-rays
- **Basic —** X-rays, extractions, fillings and sometimes crowns
- **Major —** Crowns, inlays, onlays, bridges and dentures

How do you know if you're eligible to carry benefits over to the next year? If your dental claims are less than 50% of your annual maximum, you can roll over 25% and accumulate up to 1x your annual maximum. The amount accumulated is added to your annual maximum for the year.

Let's look at an example

	Calendar year maximum	Yearly claim limit	Benefits paid	Yearly rollover amount	Accumulated rollover amount	Total maximum available
Year 1	$1,000	$500	$450	$250	$250	$1,250
Year 2	$1,000	$500	$850	$0	$250	$1,250
Year 3	$1,000	$500	$450	$250	$500	$1,500
Year 4	$1,000	$500	$0	$0	$0	$1,000
Year 5	$1,000	$500	$450	$250	$250	$1,250

You can see that in year 2, where claims were more than the yearly claim limit — which is 50% of the maximum — there was no rollover. And in year 4, where there were no claims at all, your accumulated amount went back down to zero. That's why it pays to visit the dentist regularly for preventive care.

With Maximum Accumulation, you won't leave money for costly dental procedures on the table. See the rewards of making healthy choices for your teeth — all it takes is regularly visiting your dentist.

Summary of Vision Benefits

Music Institute of Chicago

PLAN 8: 12/12/24/$130		MS 300 B
Frequency		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	
Contact lens eval/fitting	N/A	

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam with dilation as necessary	$10 copay	Up to $30
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium	N/A
Frames		
Any available frame at provider location	$0 copay, $130 allowance, 20% off balance over $130	Up to $65
Standard Lenses		
Single vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $55
Lenticular	$25 copay	Up to $55
Standard progressive lens	$90 copay	Up to $40
Premium progressive lens	See table on page 2.	Up to $40
Lens Options		
Tint (solid and gradient)	$15	N/A
Scratch resistant coating	$0	Up to $5
Polycarbonate lenses	$0 kids; $40 adults	Up to $5 kids
Ultraviolet coating	$15	N/A
Anti-reflective coating	See table on page 2.	N/A
High index lenses	20% off retail	N/A
Polarized lenses	20% off retail	N/A
Photochromic/transitions plastic	$75	N/A
Contact Lenses (in lieu of spectacle lenses)		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $104
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $104
Medically necessary	$0 copay, paid-in-full	Up to $210
Other		
Laser vision correction	15% retail price or 5% off promotional price	N/A
Additional pairs benefit	40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used	N/A
Amplifon hearing discount	40% off hearing exams and low price guarantee on discounted hearing aids	N/A
Additional discounts	20% off non-covered items with limitations	N/A
Monthly Rates		
Employee	$5.97	
Employee + spouse	$11.34	
Employee + child(ren)	$11.94	
Employee + family	$17.55	

Eligibility: All active full-time employees as defined by your employer.
Dependent coverage is available to age 26.

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- For a complete list of in-network providers near you, visit eyemedvisioncare.com/bcbsilvis or call 1.855.362.5539.
- For LASIK providers, call 1.877.5LASER6.

BlueCross BlueShield of Illinois

Vision Care

Insurance products issued by Dearborn Life Insurance Company,
701 E. 22nd St. Suite 300, Lombard, IL 60148.

Summary of Benefits Continued

Progressive Price List[2]	Member Cost In-Network
Standard progressive	$90 copay

Premium Progressives[3] as Follows:	
Tier 1	$110 copay
Tier 2	$120 copay
Tier 3	$135 copay
Tier 4	$90 copay 80% of charge less $120 allowance

Anti-Reflective Coating Price List[2]	Member Cost In-Network
Standard anti-reflective coating	$45

Premium anti-reflective[3] coatings as follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge

Other Add-ons Price List	Member Cost In-Network
Photochromic	$75
Polarized	80% of charge

Plan Exclusions

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses
2. Medical and/or surgical treatment of the eye, eyes or supporting structures
3. Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear
4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
5. Plano (non-prescription) lenses and/or contact lenses
6. Non-prescription sunglasses
7. Two pair of glasses in lieu of bifocals
8. Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order
9. Services or materials provided by any other group benefit plan providing vision care
10. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available

EyeMed | INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

[1]Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states, members may be required to pay the full retail rate. [2]Blue Cross Blue Shield of Illinois reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. [3]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary. For employee use. This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy provides the actual terms of coverage, including any exclusions, conditions and limitations to coverage.

All plans are based on a 48-month contract term and 48-month rate guarantee. Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Benefits are available from the EyeMed Vision Care, LLC provider network and are administered by First American Administrators, Inc., independent companies that offer benefits on behalf of Blue Cross and Blue Shield of Illinois. 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.

238223.0919

BlueCross BlueShield of Illinois

Group Benefit Program Summary for

Music Institute of Chicago

Group Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Illinois' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All Active Full-Time Employees
Group Term Life Benefit: Employee	$20,000
Guarantee Issue Amount - Employee	$20,000
Group Term Life Age Reduction Schedule	Benefits reduce by 35% of the original amount at age 65; and further reduce by: 50% of the original amount at age 70.
Waiver of Premium	Elimination Period: 9 Months; Duration: To age 65
Accelerated Death Benefit (ADB)	Benefit: Up to 75% of the employee's life insurance; Life expectancy: 24 months or less
Portability Feature (Life Coverage)	Not Included
Conversion	Included
Beneficiary Resource Service	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Services	Helps travelers with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance and access to other critical services and resources available via the Internet.

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Illinois

Group Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Group AD&D Benefit: Employee	Same as Basic Life
AD&D Age Reduction Schedule	Same as Basic Life

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

*Loss must occur within 365 days of accident.

AD&D PRODUCT FEATURES INCLUDED:

- ▲ Seatbelt Benefit
- ▲ Airbag Benefit
- ▲ Repatriation Benefit
- ▲ Education Benefit

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Illinois

Group Benefit Program Summary for

Music Institute of Chicago

Supplemental Term Life

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Blue Cross and Blue Shield of Illinois' Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All Active Full-Time Employees
Group Term Life Benefit: Employee	$10,000 - $500,000 in increments of $10,000
Guarantee Issue Amount - Employee	$100,000; under age 70.
Group Term Life Benefit: Spouse (Includes Domestic Partners)	$10,000 - $500,000 in increments of $10,000, not to exceed 100% of the employee benefit amount. Spouse coverage terminates at age 75.
Guarantee Issue Amount - Spouse	$20,000; under age 60.
Group Term Life Benefit: Child(ren)	Birth to 14 days: $0 Age 15 days to 6 months: $1,000 Age 6 months to 19 years (26 if full-time student): $2,500 - $10,000 in increments of $2,500
Group Term Life Age Reduction Schedule	Benefits reduce by 40% of the original amount at age 75; and further reduce by: 65% of the original amount at age 80; 73% of the original amount at age 85; 80% of the original amount at age 90; and 93% of the original amount at age 95.
Premium Waiver Type	Same as Basic Life
Accelerated Death Benefit (ADB)	Same as Basic Life
Portability Feature (Life Coverage)	Included (employee)
Conversion	Included

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Illinois

Supplemental Accidental Death & Dismemberment (AD&D)

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Group AD&D Benefit: Employee	Same as Supplemental Life
Group AD&D Benefit: Spouse (Includes Domestic Partners)	Same as Supplemental Dependent Life
Group AD&D Benefit: Child(ren)	Same as Supplemental Dependent Life
AD&D Age Reduction Schedule	Same as Supplemental Life

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of speech and hearing	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

*Loss must occur within 365 days of accident.

BlueCross BlueShield of Illinois

Music Institute of Chicago

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Supplemental Life and AD&D

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$10,000 to $500,000 in $10,000 increments. (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The spouse benefit may not exceed the employee benefit amount.

Guarantee Issue*

Employee	**$100,000; under age 70.**
Spouse	**$20,000; under age 60.**

*Assumes 37% participation

Child Coverage

Birth to 14 days:	**$0**
15 days to 6 months:	**$1,000**
6 months to age 19:	**$2,500 to $10,000 in increments of $2,500**
(Student Maximum Age: 26)	

Benefits reduce by 40% of the original amount at age 75; and further reduce by: 65% of the original amount at age 80; 73% of the original amount at age 85; 80% of the original amount at age 90; and 93% of the original amount at age 95.

Employee Supplemental Life

Monthly rates per $1,000

Age	Rates
Under 20	$0.050
20-24	$0.050
25-29	$0.050
30-34	$0.055
35-39	$0.084
40-44	$0.135
45-49	$0.207
50-54	$0.338
55-59	$0.531
60-64	$0.737
65-69	$1.360
70+	$2.258

Supplemental AD&D

Monthly rates per $1,000

Employee	$ 0.024

Dependent Life (Children)

Monthly Premium per Family

	Life	AD&D
$2,500	$0.50	$0.140
$10,000	$2.00	$0.560

Supplemental Life and AD&D

Premium Cost (Based on 12 payroll deductions per year)

		ATTAINED AGE											
Benefit Amount	EE AD&D	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.24	$0.50	$0.50	$0.50	$0.55	$0.84	$1.35	$2.07	$3.38	$5.31	$7.37	$13.60	$22.58
$20,000	$0.48	$1.00	$1.00	$1.00	$1.10	$1.68	$2.70	$4.14	$6.76	$10.62	$14.74	$27.20	$45.16
$30,000	$0.72	$1.50	$1.50	$1.50	$1.65	$2.52	$4.05	$6.21	$10.14	$15.93	$22.11	$40.80	$67.74
$40,000	$0.96	$2.00	$2.00	$2.00	$2.20	$3.36	$5.40	$8.28	$13.52	$21.24	$29.48	$54.40	$90.32
$50,000	$1.20	$2.50	$2.50	$2.50	$2.75	$4.20	$6.75	$10.35	$16.90	$26.55	$36.85	$68.00	$112.90
$60,000	$1.44	$3.00	$3.00	$3.00	$3.30	$5.04	$8.10	$12.42	$20.28	$31.86	$44.22	$81.60	$135.48
$70,000	$1.68	$3.50	$3.50	$3.50	$3.85	$5.88	$9.45	$14.49	$23.66	$37.17	$51.59	$95.20	$158.06
$80,000	$1.92	$4.00	$4.00	$4.00	$4.40	$6.72	$10.80	$16.56	$27.04	$42.48	$58.96	$108.80	$180.64
$90,000	$2.16	$4.50	$4.50	$4.50	$4.95	$7.56	$12.15	$18.63	$30.42	$47.79	$66.33	$122.40	$203.22
$100,000	$2.40	$5.00	$5.00	$5.00	$5.50	$8.40	$13.50	$20.70	$33.80	$53.10	$73.70	$136.00	$225.80
$150,000	$3.60	$7.50	$7.50	$7.50	$8.25	$12.60	$20.25	$31.05	$50.70	$79.65	$110.55	$204.00	$338.70
$200,000	$4.80	$10.00	$10.00	$10.00	$11.00	$16.80	$27.00	$41.40	$67.60	$106.20	$147.40	$272.00	$451.60
$250,000	$6.00	$12.50	$12.50	$12.50	$13.75	$21.00	$33.75	$51.75	$84.50	$132.75	$184.25	$340.00	$564.50
$300,000	$7.20	$15.00	$15.00	$15.00	$16.50	$25.20	$40.50	$62.10	$101.40	$159.30	$221.10	$408.00	$677.40
$350,000	$8.40	$17.50	$17.50	$17.50	$19.25	$29.40	$47.25	$72.45	$118.30	$185.85	$257.95	$476.00	$790.30
$400,000	$9.60	$20.00	$20.00	$20.00	$22.00	$33.60	$54.00	$82.80	$135.20	$212.40	$294.80	$544.00	$903.20
$450,000	$10.80	$22.50	$22.50	$22.50	$24.75	$37.80	$60.75	$93.15	$152.10	$238.95	$331.65	$612.00	$1,016.10
$500,000	$12.00	$25.00	$25.00	$25.00	$27.50	$42.00	$67.50	$103.50	$169.00	$265.50	$368.50	$680.00	$1,129.00

BlueCross BlueShield of Illinois

Music Institute of Chicago

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Supplemental Life and AD&D

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$10,000 to $500,000 in $10,000 increments.**
(not to exceed 100% of the employee benefit)

Note: Spouse may not have coverage unless the employee has coverage.

The spouse benefit may not exceed the employee benefit amount.

Guarantee Issue*

Employee	**$100,000; under age 70.**
Spouse	**$20,000; under age 60.**

*Assumes 37% participation

Child Coverage

Birth to 14 days:	**$0**
15 days to 6 months:	**$1,000**
6 months to age 19:	**$2,500 to $10,000 in increments of $2,500**
(Student Maximum Age: 26)	

Spouse coverage terminates at age 75.

Spouse
Supplemental Life
Monthly rates per $1,000

Age	Rates
Under 20	$0.050
20-24	$0.050
25-29	$0.050
30-34	$0.055
35-39	$0.084
40-44	$0.135
45-49	$0.207
50-54	$0.338
55-59	$0.531
60-64	$0.737
65-69	$1.360
70-74	$2.258

Spouse coverage terminates at age 75.

Supplemental AD&D
Monthly rates per $1,000

Spouse	$ 0.024

Dependent Life (Children)
Monthly Premium per Family

	Life	AD&D
$2,500	$0.50	$0.140
$10,000	$2.00	$0.560

Supplemental Life and AD&D

Premium Cost (Based on 12 payroll deductions per year)

		ATTAINED AGE											
Benefit Amount	Spouse AD&D	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$10,000	$0.24	$0.50	$0.50	$0.50	$0.55	$0.84	$1.35	$2.07	$3.38	$5.31	$7.37	$13.60	$22.58
$20,000	$0.48	$1.00	$1.00	$1.00	$1.10	$1.68	$2.70	$4.14	$6.76	$10.62	$14.74	$27.20	$45.16
$30,000	$0.72	$1.50	$1.50	$1.50	$1.65	$2.52	$4.05	$6.21	$10.14	$15.93	$22.11	$40.80	$67.74
$40,000	$0.96	$2.00	$2.00	$2.00	$2.20	$3.36	$5.40	$8.28	$13.52	$21.24	$29.48	$54.40	$90.32
$50,000	$1.20	$2.50	$2.50	$2.50	$2.75	$4.20	$6.75	$10.35	$16.90	$26.55	$36.85	$68.00	$112.90
$60,000	$1.44	$3.00	$3.00	$3.00	$3.30	$5.04	$8.10	$12.42	$20.28	$31.86	$44.22	$81.60	$135.48
$70,000	$1.68	$3.50	$3.50	$3.50	$3.85	$5.88	$9.45	$14.49	$23.66	$37.17	$51.59	$95.20	$158.06
$80,000	$1.92	$4.00	$4.00	$4.00	$4.40	$6.72	$10.80	$16.56	$27.04	$42.48	$58.96	$108.80	$180.64
$90,000	$2.16	$4.50	$4.50	$4.50	$4.95	$7.56	$12.15	$18.63	$30.42	$47.79	$66.33	$122.40	$203.22
$100,000	$2.40	$5.00	$5.00	$5.00	$5.50	$8.40	$13.50	$20.70	$33.80	$53.10	$73.70	$136.00	$225.80
$150,000	$3.60	$7.50	$7.50	$7.50	$8.25	$12.60	$20.25	$31.05	$50.70	$79.65	$110.55	$204.00	$338.70
$200,000	$4.80	$10.00	$10.00	$10.00	$11.00	$16.80	$27.00	$41.40	$67.60	$106.20	$147.40	$272.00	$451.60
$250,000	$6.00	$12.50	$12.50	$12.50	$13.75	$21.00	$33.75	$51.75	$84.50	$132.75	$184.25	$340.00	$564.50
$300,000	$7.20	$15.00	$15.00	$15.00	$16.50	$25.20	$40.50	$62.10	$101.40	$159.30	$221.10	$408.00	$677.40
$350,000	$8.40	$17.50	$17.50	$17.50	$19.25	$29.40	$47.25	$72.45	$118.30	$185.85	$257.95	$476.00	$790.30
$400,000	$9.60	$20.00	$20.00	$20.00	$22.00	$33.60	$54.00	$82.80	$135.20	$212.40	$294.80	$544.00	$903.20
$450,000	$10.80	$22.50	$22.50	$22.50	$24.75	$37.80	$60.75	$93.15	$152.10	$238.95	$331.65	$612.00	$1,016.10
$500,000	$12.00	$25.00	$25.00	$25.00	$27.50	$42.00	$67.50	$103.50	$169.00	$265.50	$368.50	$680.00	$1,129.00

BlueCross BlueShield of Illinois

Group Benefit Program Summary for

Music Institute of Chicago

Voluntary Group Short-term Disability Insurance (STD)

Today, most Americans would not be able to make payments on their homes or keep their family financially stable without their current salary. STD reduces the burden during these unstable times. It is a convenient, economical way of securing an income while out of work from an unexpected injury or illness. Voluntary Group STD is a guaranteed issue coverage, which requires no health questionnaires to complete.

Eligibility	All Active Full-Time Employees
Group STD Benefit	60% of basic weekly earnings
Weekly Maximum Benefit	$1,000
Benefits Are Payable On	8th day for Injury 8th day for Sickness
Maximum Benefit Period	13 Weeks or until LTD begins, whichever is earlier
Total Disability	Total Disability means that due to Injury or Sickness the employee is unable to perform all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any, are less than the percentage (20%) of the employee's pre-disability weekly earnings.
Partial Disability	Partial Disability means that during the elimination period the employee is able to perform some, but not all, of the material and substantial duties of the employee's regular occupation. After the elimination period, partial disability means that due to Injury or Sickness the employee is able to perform some but not all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any are at least the minimum percentage (20%), but less than the maximum percentage of the employee's pre-disability weekly earnings (80%).
Pre-Existing Condition Limitation	3/12 - A Pre-Existing Condition is a Sickness or Injury for which you have received treatment within 3 months prior to your effective date. Any disability contributed to or caused by a Pre-Existing Condition within the first 12 months of your effective date will not be covered.
Additional Features	Survivor Benefit, Work Incentive Benefit, Worksite Modification Benefit, FMLA Coverage Extension, Recurrent Disability

BlueCross BlueShield of Illinois

Voluntary Short-Term Disability Insurance

Music Institute of Chicago

Benefit Schedule

Benefit Percentage	60% of Weekly Earnings* to a maximum weekly benefit of $1,000
Elimination Period - Injury	7 Days
Elimination Period - Sickness	7 Days
Benefits Begin – Injury	8th Day
Benefits Begin – Sickness	8th Day
Maximum Period Payable	13 weeks or until LTD begins, whichever is earlier
Pre-Existing Conditions Limitation	3/12
Work Incentive Benefit, Worksite Modification Benefit, Continuity of Coverage	Included

Monthly Rate per $10 of Weekly Benefit	
Age	Rate
Under 20	$0.603
20-24	$0.603
25-29	$0.716
30-34	$0.707
35-39	$0.528
40-44	$0.471
45-49	$0.509
50-54	$0.603
55-59	$0.726
60-64	$0.810
65-69	$1.008
70+	$1.300

**Weekly Earnings means your annual, monthly or weekly rate of earnings from your employer in effect immediately prior to the date disability begins. It includes total income before taxes, including deduction made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. . It does not include bonuses, overtime pay or any other extra compensation other than commissions. Commissions will be averaged over the 12-month period prior to the date disability begins.*

Sample Premium Calculation

(Sample assumes a 30-year-old employee with $45,000 in annual earnings)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium
$45,000 ÷ 52	=	$865	x	$0.60	=	$51.90	x	$0.707	=	$36.69

Your Premium Calculation

(Enter your salary and the rate for your current age from the table above)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium
$ ÷ 52	=	$	x	$0.60	=	$	x	$	=	$

To determine Bi-Weekly Premium, multiply Monthly Premium by 12, and then divide by 26.
To determine Semi-Monthly Premium, multiply Monthly Premium by 12, and then divide by 24.
To determine Weekly Premium, multiply Monthly Premium by 12, and then divide by 52.

This information is only a product highlight. This Premium Cost Chart is for illustrative purposes only; your premium cost may be slightly higher or lower due to rounding. NOTE: For purposes of this illustration, we have assumed a 40-hour work week. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period. Product features and availability vary by state and company, and are solely the responsibility of each affiliate. Refer to your certificate for complete details and limitations of coverage.

BlueCross BlueShield of Illinois

Group Benefit Program Summary for
Music Institute of Chicago
Group Long-term Disability Insurance (LTD)

Without a steady income, most people would not be able to make payments on their homes or keep their family financially stable. LTD reduces the burden during these unstable times. It is a convenient, economical way of securing an income while out of work from an unexpected injury or illness. Your employer has made LTD coverage available for you to enroll in. Below are some of the major features of this program.

Eligibility	All Active Full-Time Employees
Group LTD Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100 or 10% of gross monthly earnings, whichever is greater
Elimination Period	90 days
Maximum Period Payable	Social Security Normal Retirement Age (SSNRA)
Social Security Offset Method	Primary and Family Integration
Mental Disorder Limitation	24 Months
Substance Abuse Limitation	24 Months
Special Conditions Limitation	No limitation
Pre-Existing Condition Limitation	3/12 - A Pre-Existing Condition is a Sickness or Injury for which you have received treatment within 3 months prior to your effective date. Any disability contributed to or caused by a Pre-Existing Condition within the first 12 months of your effective date will not be covered.
Rehabilitation Incentive Income (RII)	RII is offered to employees who agree to take part in a rehabilitation plan, structured to return them to gainful employment in another occupation because they can not return to their regular occupation. During the first 12 months, RII is equal to the monthly benefit. If disability earnings during this period exceed 100% of indexed predisability earnings, the monthly benefit is reduced by the excess. After 12 months, RII is equal to the monthly benefit reduced by multiplying the monthly benefit by the adjusted loss of salary ratio. Includes Day Care Expense Benefit.
Disability Resource Service	In addition to the resource services available on-line at GuidanceResources.com, Disability Resource Services provides a 24-hour telephonic support for all LTD insureds for behavioral health issues. A staff of master degree clinicians are available to provide each caller with assessment, counseling and referral advice for face-to-face counseling. Face-to-face counseling - Up to three face-to-face counseling sessions per year to address appropriate behavioral health issues.
Additional Features	Work Incentive Benefit, Survivor Benefit

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

BlueCross BlueShield of Illinois

LTD Definition of Disability:

Total Disability	Total Disability means that during the first 24 consecutive months of benefits due to Injury or Sickness the employee is unable to perform all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any, are less than the percentage (20%) of the employee's pre-disability weekly earnings.
Partial Disability	Partial Disability means that during the elimination period the employee is able to perform some, but not all, of the material and substantial duties of the employee's regular occupation. After the elimination period, partial disability means that due to Injury or Sickness the employee is able to perform some but not all of the material and substantial duties of the employee's regular occupation, and the employee's disability earnings, if any are at least the minimum percentage (20%), but less than the maximum percentage of the employee's pre-disability weekly earnings (60%).

Important Notices

I. Initial Notice About Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" without being considered a late applicant if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)
If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or move out of the prior plan's HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children's Health Insurance Program
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.
You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

Flexible Spending Accounts (FSA)

As an employee, you have access to a standard **Flexible Spending Account (FSA**) and a Dependent Care Flexible Spending Account. The Standard FSA allows you to take advantage of federal tax laws that permit eligible medical, dental & vision expenses to be paid with pre-tax dollars. A Dependent Care FSA also allow you to set aside pre-tax funds for eligible dependent care expenses and a Limited Purpose FSA is for those HSA enrollees that would like to set aside additional pre-tax dollars for dental & vision expenses only.

Essentially, you set aside a portion of your paycheck before taxes, and then use that money to pay yourself back for IRS-eligible medical, dental, vision, or dependent care expenses. Contributions are not subject to Social Security (FICA), federal income tax or, in most cases, state and local income taxes. The more expenses you pay through these accounts, the more you save in taxes. 2018 maximum amount set by IRS is $2650.

ANNUAL ENROLLMENT

While the other benefits have an alternative plan anniversary (or renewal) date, the FSA anniversary date is January 1st of each year. Enrollment in an FSA does not automatically continue from year to year. It is necessary to enroll in FSA's every year during Open Enrollment (typically in December, to take effect for the following calendar year). Once Open Enrollment is closed, you will only be able to enroll in an FSA during the year if you have a qualified family status change.

USE IT OR LOSE IT

The MIC FSA plan incorporates a GRACE PERIOD that allows participants to INCUR FSA claims up to mid-March of the following year, towards the current plan year. It also allows for a RUNOUT PERIOD until March 31st of the following year to SUBMIT FSA claims for the current plan year. Any funds not claimed by the deadline will be forfeited. Therefore, you should estimate your FSA-eligible expenses carefully.

DEPENDENT CARE EXPENSE INFORMATION

Benefit Reimburses you for expenses you incur to care for your dependent children or a disabled spouse or other disabled tax-qualified dependent who spends at least eight hours a day at your home while you work. If you are married, your spouse must also work, be a full-time student, or be disabled.

Eligible Examples: Day care expenses at licensed nursery school, preschool, day camp and/or child care center, or baby sitter expenses while you work (a baby sitter cannot be your child or dependent under age 19

B.PRE-EXISTING CONDITION EXCLUSION RULES

Pre-existing condition exclusion rules do not apply to group health plans with effective dates on or after January 1, 2014.

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six- month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. "Waiting period" generally refers to a delay between the first day of employment and the first day of coverage under the plan. The pre-existing condition exclusion does not apply to pregnancy or to an individual under the age of 19.

This pre-existing condition exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (FOR NON-GRANDFATHERED HEALTH PLANS ONLY)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries:
If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

For plans that require or allow for the designation of a primary care provider for a child:
For children, you may designate a pediatrician as the primary care provider.

Important Notices Cont'd

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

III. Legally Required Notices

A. CREDIBLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

Since January 1, 2006, Medicare prescription drug coverage (Medicare Part D) has been available to everyone eligible for Medicare. Music Institute of Chicago has determined that the prescription drug coverage offered by its employee health coverage plans is expected to pay as much in benefits as the standard Medicare prescription drug coverage; that is, it is credible coverage.

Music Institute of Chicago employees who are eligible for Medicare, or who have dependents covered on their health coverage who are eligible for Medicare, will not pay a premium penalty for not enrolling in a Medicare Part D prescription drug plan while covered under Music Institute of Chicago employee health plans. If your coverage with Music Institute of Chicago terminates, you and/or your dependent could be subject to a premium penalty for late enrollment in a Medicare Part D prescription drug plan if you experience a break in credible coverage for 63 continuous days or longer before enrolling in a Medicare Part D plan. There is no reason for employees currently covered under Music Institute of Chicago employee health coverage to enroll in a Medicare Part D prescription drug plan.

For more information about Medicare prescription drug coverage, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and treatment of physical complications of the mastectomy, including lymph edema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your medical plan.

C. MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

Important Notices Cont'd

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

BlueCross BlueShield Medical Premiums, Effective 4/1/2020

PPO NPP83433

PPO Network

PPO MPPC3836

PPO Network

Rates

Rates / Class Tier	Medical Plan 1		Medical Plan 2	
	Employee Monthly Cost	Total Premium	Employee Monthly Cost	Total Premium
Employee only	$423.67	$901.20	$340.44	$817.97
Employee + spouse	$1,316.64	$1,794.17	$1,150.94	$1,628.47
Employee + child(ren)	$994.45	$1,471.98	$858.51	$1,336.04
Employee + family	$1,887.43	$2,364.96	$1,669.01	$2,146.54

BE HSA PPO MPSC 1807

PPO Network

BE HSA PPO MIEEA 207

PPO Network

Rates

Rates / Class Tier	Medical Plan 3		Medical Plan 4	
	Employee Monthly Cost	Total Premium	Employee Monthly Cost	Total Premium
Employee only	$323.38	$800.91	$229.73	$707.26
Employee + spouse	$1,116.96	$1,594.49	$930.53	$1,408.06
Employee + child(ren)	$830.63	$1,308.16	$677.68	$1,155.21
Employee + family	$1,624.22	$2,101.75	$1,378.48	$1,856.01

HMO MIBAH201
Blue Advantage
HMO Network

HMO MIBAH202
Blue Advantage
HMO Network

Rates

Rates / Class Tier	Medical Plan 5		Medical Plan 6	
	Employee Monthly Cost	Total Premium	Employee Monthly Cost	Total Premium
Employee only	$238.77	$716.30	$252.37	$729.90
Employee + spouse	$948.52	$1,426.05	$975.31	$1,453.14
Employee + child(ren)	$692.44	$1,169.97	$714.66	$1,192.19
Employee + family	$1,402.20	$1,879.73	$1,437.90	$1,915.43

Deductibles, out-of-pocket totals, copays, and drug benefits all vary by plan. Please pay close attention to the details as you make your selection. The lowest monthly premium may not be the best choice. Review the Summary of Benefits and Coverage (SBC) for each plan.

MIC
Music Institute of Chicago

Principal Dental Premiums, Effective 4/1/2020

Rates

	Dental Rates	
Rates / Class Tier	**Plan 1 DPPO (High)**	**Plan 2 DPPO (Low)**
Employee only	$42.58	$23.90
Employee + spouse	$85.22	$46.47
Employee + 1 child	$85.22	$46.47
Employee & 2+ child(ren)	$112.63	$61.26
Employee + family	$112.63	$61.26

Deductibles, out-of-pocket totals, copays, and dental benefits vary by plan. Please pay close attention to the details as you make your selection. The lowest monthly premium may not be the best choice.

EyeMed Vision Rates, Effective 4/1/2020

Rates

	VSP Vision Plan	
Rates / Class Tier	**Employee Monthly Cost**	**Total Premium**
Employee only	$0.00	$5.97
Employee + Spouse	$5.37	$11.34
Employee + 1 Child	$5.97	$11.94
Employee & 2+ Children	$5.97	$11.94
Family	$11.58	$17.55

Important Contact Information

Below is a list of important contact information from our employee benefits advisor, Better Business Planning:

- Lori Fuentes: Account Manager (claim issues, billing issues, general benefits questions, etc.)
  630-775-8319 (direct)
  lori@benefits411.com

- Rosa LoIacono: Flexible Spending Accounts
  630-775-8323 (direct)
  rosetta@bbpadmin.com

- Jim Vidmich: Benefits Consultant
  630-775-8530 (direct)
  james@benefits411.com

Notes: