Illinois Health Coverage Disclosure Requirement

Illinois has passed a law (Public Act 102-0630) that imposes new disclosure requirements on employers that sponsor group health insurance. The law, known as the Consumer Coverage Disclosure Act, was enacted on August 27, 2021 and is effective immediately.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Consumer Coverage Disclosure Act.

Section 5. Definitions. As used in this Act:

"Employee" means any individual permitted to work by an employer.

"Employer" means an individual, partnership, corporation, association, business, trust, person, or entity for whom employees are gainfully employed in Illinois and includes the State of Illinois, any State officer, department or agency, any unit of local government, and any school district.

Section 10. Required disclosures.

(a) An employer that provides group health insurance coverage to its employees shall, upon hire, annually thereafter, and upon request from an employee, provide all employees eligible for the coverage a written list of the covered benefits included in the group health insurance coverage in a format that easily compares those covered benefits with the essential health insurance benefits required of individual health insurance coverage regulated by the State of Illinois.

(b) The Department of Insurance shall provide information outlining the essential health insurance benefits of individual health insurance coverage regulated by the State of Illinois, which an employer may use to inform eligible employees of benefits included or not included in their health insurance coverage.

(c) An employer may comply with the requirements of subsection (a) by providing the required information by email to its employees or providing the information on a website that an employee is able to regularly access.

ILLINOIS 2020 EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Small Group Market
Issuer Name	Blue Cross Blue Shield of Illinois
Product Name	PPO
Plan Name	Blue PPO Gold 011
Supplemented Categories (Supplementary Plan Type)	Pediatric dental (CHIP) Pediatric vision (FEDVIP)

BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No				
Routine Dental Services (Adult)	No	Covered	No				Limitations vary based on procedures.
Infertility Treatment	Yes	Covered	No				Limitations vary based on procedures.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No			Inpatient Private Duty Nursing Service is not covered.	If Private Duty Nursing Service is recommended by your Physician, you must call the Medical Services Advisory Program (MSA) at least 1 business day prior to receiving services.
Routine Eye Exam (Adult)	No	Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	No	Not Covered	No				
Emergency Room Services	Yes	Covered	No				
Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	Yes	Covered	No				
Cosmetic Surgery	No	Not Covered	No				Cosmetic surgery for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases is covered.
Skilled Nursing Facility	Yes	Covered	No				If Skilled Nursing Facility is recommended by your Physician, you must call the Medical Services Advisory Program (MSA) at least 1 business day prior to receiving services.
Prenatal and Postnatal Care	Yes	Covered	No				Benefits will be available for that care from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage.
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	No	Not Covered	No				
Habilitation Services	Yes	Covered	No				Treatment must be medically necessary and therapeutic and not investigational.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Chiropractic Care	Yes	Covered	Yes	25	Visit(s) per Benefit Period		
Durable Medical Equipment	Yes	Covered	No				
Hearing Aids	Yes	Covered	Yes	2	Item(s) per 3 Years		Benefits are for bone anchored hearing aids. Quantity limit applies to hearing aids for children.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				Benefit provided for outpatient services and when these services are related to surgery or medical care.
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	No	Not Covered	No				Only covered for persons diagnosed with diabetes.
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period		
Dental Check-Up for Children	Yes	Covered	No				
Rehabilitative Speech Therapy	No	Not Covered	No				
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Not Covered	No				
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				Benefit provided for outpatient services and when these services are related to surgery or medical care.
X-rays and Diagnostic Imaging	Yes	Covered	No				Benefit provided for outpatient services and when these services are related to surgery or medical care.
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				Limitations vary based on procedures.
Major Dental Care - Child	Yes	Covered	No				Limitations vary based on procedures.
Basic Dental Care - Adult	No	Covered	No				Limitations vary based on procedures.
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				Abortions are only covered when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
Transplant	Yes	Covered	No			No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.	
Accidental Dental	Yes	Covered	No				
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				Services must be rendered by a physician, or duly certified, registered or licensed health care professional with expertise in diabetes management.
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Reconstructive Surgery	Yes	Covered	No				Only includes benefits for mastectomy-related services.

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	22
Analgesics	Opioid Analgesics, Long-acting	8
Analgesics	Opioid Analgesics, Short-acting	19
Anesthetics	Local Anesthetics	3
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	3
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence	4
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	1
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	3
Antibacterials	Aminoglycosides	2
Antibacterials	Antibacterials, Other	13
Antibacterials	Beta-lactam, Cephalosporins	8
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Carbapenems	0
Antibacterials	Macrolides	4
Antibacterials	Quinolones	6
Antibacterials	Sulfonamides	2
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	8
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	8
Anticonvulsants	Sodium Channel Agents	8
Antidementia Agents	Antidementia Agents, Other	1
Antidementia Agents	Cholinesterase Inhibitors	3
Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist	1
Antidepressants	Antidepressants, Other	9
Antidepressants	Monoamine Oxidase Inhibitors	3
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	13
Antidepressants	Tricyclics	11
Antiemetics	Antiemetics, Other	9
Antiemetics	Emetogenic Therapy Adjuncts	6
Antifungals	No USP Class	10
Antigout Agents	No USP Class	6
Antimigraine Agents	Ergot Alkaloids	2
Antimigraine Agents	Prophylactic	4
Antimigraine Agents	Serotonin (5-HT) Receptor Agonist	7
Antimyasthenic Agents	Parasympathomimetics	2

CATEGORY	CLASS	SUBMISSION COUNT
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	8
Antineoplastics	Alkylating Agents	5
Antineoplastics	Antiandrogens	5
Antineoplastics	Antiangiogenic Agents	3
Antineoplastics	Antiestrogens/Modifiers	4
Antineoplastics	Antimetabolites	5
Antineoplastics	Antineoplastics, Other	5
Antineoplastics	Aromatase Inhibitors, 3rd Generation	4
Antineoplastics	Enzyme Inhibitors	2
Antineoplastics	Molecular Target Inhibitors	41
Antineoplastics	Monoclonal Antibody/Antibody-Drug Conjugate	0
Antineoplastics	Retinoids	2
Antineoplastics	Treatment Adjuncts	10
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	12
Antiparkinson Agents	Anticholinergics	3
Antiparkinson Agents	Antiparkinson Agents, Other	4
Antiparkinson Agents	Dopamine Agonists	5
Antiparkinson Agents	Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors	3
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	11
Antipsychotics	2nd Generation/Atypical	10
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	3
Antivirals	Anti-cytomegalovirus (CMV) Agents	1
Antivirals	Anti-hepatitis B (HBV) Agents	5
Antivirals	Anti-hepatitis C (HCV) Agents	7
Antivirals	Antiherpetic Agents	3
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	5
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	7
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	18
Antivirals	Anti-HIV Agents, Other	7
Antivirals	Anti-HIV Agents, Protease Inhibitors (PI)	11
Antivirals	Anti-influenza Agents	4
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	8

CATEGORY	CLASS	SUBMISSION COUNT
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	8
Bipolar Agents	Mood Stabilizers	5
Blood Glucose Regulators	Antidiabetic Agents	21
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	11
Blood Products and Modifiers	Anticoagulants	9
Blood Products and Modifiers	Blood Products and Modifiers, Other	8
Blood Products and Modifiers	Hemostasis Agents	1
Blood Products and Modifiers	Platelet Modifying Agents	8
Cardiovascular Agents	Alpha-adrenergic Agonists	4
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	8
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	10
Cardiovascular Agents	Antiarrhythmics	14
Cardiovascular Agents	Beta-adrenergic Blocking Agents	12
Cardiovascular Agents	Calcium Channel Blocking Agents, Dihydropyridines	7
Cardiovascular Agents	Calcium Channel Blocking Agents, Nondihydropyridines	2
Cardiovascular Agents	Cardiovascular Agents, Other	6
Cardiovascular Agents	Diuretics, Loop	4
Cardiovascular Agents	Diuretics, Potassium-sparing	4
Cardiovascular Agents	Diuretics, Thiazide	6
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	7
Cardiovascular Agents	Dyslipidemics, Other	7
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	3
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	4
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	5
Central Nervous System Agents	Central Nervous System, Other	13
Central Nervous System Agents	Fibromyalgia Agents	3
Central Nervous System Agents	Multiple Sclerosis Agents	8
Dental and Oral Agents	No USP Class	7
Dermatological Agents	Acne and Rosacea Agents	10
Dermatological Agents	Dermatitis and Pruritus Agents	16
Dermatological Agents	Dermatological Agents, Other	15
Dermatological Agents	Pediculicides/Scabicides	7

CATEGORY	CLASS	SUBMISSION COUNT
Dermatological Agents	Topical Anti-infectives	17
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral Replacement	5
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral/Metal Modifiers	5
Electrolytes/ Minerals/ Metals/ Vitamins	Phosphate Binders	3
Electrolytes/ Minerals/ Metals/ Vitamins	Potassium Binders	1
Electrolytes/ Minerals/ Metals/ Vitamins	Vitamins	1
Gastrointestinal Agents	Anti-Constipation Agents	6
Gastrointestinal Agents	Anti-Diarrheal Agents	4
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	3
Gastrointestinal Agents	Gastrointestinal Agents, Other	10
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	2
Gastrointestinal Agents	Protectants	3
Gastrointestinal Agents	Proton Pump Inhibitors	5
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	No USP Class	7
Genitourinary Agents	Antispasmodics, Urinary	7
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	9
Genitourinary Agents	Genitourinary Agents, Other	7
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	9
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)	No USP Class	4
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	2
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	2
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	16
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	18
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	5
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	No USP Class	3
Hormonal Agents, Suppressant (Adrenal)	No USP Class	1
Hormonal Agents, Suppressant (Pituitary)	No USP Class	8
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2
Immunological Agents	Angioedema Agents	2
Immunological Agents	Immunoglobulins	1
Immunological Agents	Immunological Agents, Other	10
Immunological Agents	Immunostimulants	4
Immunological Agents	Immunosuppressants	13
Inflammatory Bowel Disease Agents	Aminosalicylates	4

CATEGORY	CLASS	SUBMISSION COUNT
Inflammatory Bowel Disease Agents	Glucocorticoids	7
Metabolic Bone Disease Agents	No USP Class	14
Ophthalmic Agents	Ophthalmic Agents, Other	3
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	8
Ophthalmic Agents	Ophthalmic Anti-Infectives	18
Ophthalmic Agents	Ophthalmic Anti-inflammatories	12
Ophthalmic Agents	Ophthalmic Beta-Adrenergic Blocking Agents	6
Ophthalmic Agents	Ophthalmic Intraocular Pressure Lowering Agents, Other	7
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	4
Otic Agents	No USP Class	9
Respiratory Tract/ Pulmonary Agents	Antihistamines	10
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	7
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	3
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	6
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	13
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	2
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	9
Respiratory Tract/ Pulmonary Agents	Pulmonary Fibrosis Agents	2
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	3
Skeletal Muscle Relaxants	No USP Class	6
Sleep Disorder Agents	Sleep Promoting Agents	9
Sleep Disorder Agents	Wakefulness Promoting Agents	3

CSM Corporation BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No				
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Not Covered	No				Limitations of diagnosis of infertility
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Not Covered	No				
Routine Eye Exam (Adult)	No	Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	No	Covered	No				
Emergency Room Services	Yes	Covered	No				
Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	Yes	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Cosmetic surgery for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases is covered
Skilled Nursing Facility	Yes	Covered	No				Skilled Nursing Facility must be ordered by your Physician
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	No	Covered	No				
Habilitation Services	Yes	Covered	No				Treatment must be medically necessary and therapeutic and not investigational.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Chiropractic Care	Yes	Covered	No				
Durable Medical Equipment	Yes	Covered	No				
Hearing Aids	Yes	Covered	Yes	2	Item(s) per 3 Years		Hearing aids are for children 18 or younger
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	No	Not Covered	No				Only covered for persons diagnosed with diabetes.
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Not Covered	No				
Dental Check-Up for Children	Yes	Not Covered	No				
Rehabilitative Speech Therapy	No	Covered	No				
Rehabilitative Occupational and Rehabilitative Physical Therapy	No	Covered	No				
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Not Covered	No				
Orthodontia - Child	Yes	Not Covered	No				
Major Dental Care - Child	Yes	Not Covered	No				
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				
Transplant	Yes	Covered	No				
Accidental Dental	Yes	Covered	No				
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No				
Reconstructive Surgery	Yes	Covered	No				

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
CSM CORPORATION

Coverage Period: Beginning on or after 01/01/2022
Coverage for: Individual/Family | Plan Type: PPO

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.bluecrossmnonline.com or call 1-866-873-5943. 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.healthcare.gov/sbc-glossary or call 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual / **$3,000** family medical in-network **$3,000** individual / **$6,000** family medical out-of-network	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. Well child care, prenatal care and in-network 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 https://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?	**$8,550** individual / **$17,100** family medical and drug in-network **$17,100** individual / **$34,200** family medical and drug out-of-network	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, balance-billing charges (unless balanced billing is prohibited), 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 an in-network provider?	Yes. Your network is Aware. See https://www.bluecrossmnonline.com/find-a-doctor/#/home or call 1-866-873-5943 for a list of in-network 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 in-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
		In-Network Provider (You will pay the least)	Out-of-Network 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 copay/office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	None
	Specialist visit	$60 copay/office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: 40% coinsurance Adult: 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)	No charge	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 www.bluecrossmnonline.com	Preferred generic drugs	$10.00 copay/prescription (retail) $20.00 copay/prescription (mail service) $20.00 copay/prescription (90dayRx retail)	$10.00 copay/prescription (retail)	Covers up to a 31-day supply (retail prescription). 90-day supply (mail order prescription and 90dayRx retail prescription). No coverage for mail order and

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	$50.00 copay or 20% coinsurance, whichever is greater, to a maximum of $100.00/prescription (retail) $100.00 copay or 20% coinsurance, whichever is greater, to a maximum of $200.00/prescription (mail service) $100.00 copay or 20% coinsurance, whichever is greater, to a maximum of $200.00/ prescription (90dayRx retail)	$50.00 copay or 20% coinsurance, whichever is greater, to a maximum of $100.00/ prescription (retail)	90dayRx retail services from out-of-network providers.
	Non-preferred drugs	Non-preferred generic drugs: $10.00 copay/prescription (retail) $20.00 copay/prescription (mail service) $20.00 copay/prescription (90dayRx retail) Non-preferred brand drugs: $100.00 copay or 20% coinsurance, whichever is greater, to a maximum of $200.00/prescription (retail) $200.00 copay or 20% coinsurance, whichever is greater, to a maximum of $400.00/prescription (mail service) $200.00 copay or 20% coinsurance, whichever is greater, to a maximum of $400.00/prescription (90dayRx retail)	Non-preferred generic drugs: $10.00 copay/prescription (retail) Non-preferred brand drugs: $100.00 copay or 20% coinsurance, whichever is greater, to a maximum of $200.00/prescription (retail)	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	20% coinsurance up to a maximum of $1,000.00 for preferred specialty drugs. 20% coinsurance for non-preferred specialty drugs.	Not covered	Covers up to a 31-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for outpatient hospital facility & ambulatory surgery center	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance for outpatient hospital facility & ambulatory surgery center	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$20 physician or $60 specialist copay/office visit whichever is applicable, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use services	Outpatient services	$20 copay/office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Services for marriage/couples counseling are not covered.
	Inpatient services including residential adult mental health treatment	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $20 copay/primary care office visit or $60 copay/specialist office visit, deductible does not apply; 20% coinsurance for all other services	Prenatal care: 40% coinsurance Postnatal care: 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	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 for occupational therapy, physical therapy, and speech therapy	40% coinsurance for occupational therapy, physical therapy, and speech therapy	None
	Habilitation services	20% coinsurance for occupational therapy, physical therapy, and speech therapy	40% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	20% coinsurance	40% coinsurance	Combined 120 days per person per benefit period.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice service	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Age 0 through 5: 40% coinsurance Age 6 through 18: 40% coinsurance	None
	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check-up	Not covered	Not covered	No coverage for these services

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
- Bariatric surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care

• Cosmetic surgery (except as specified in plan benefits) • Dental care (except as specified in plan benefits)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Hearing aids for individuals 18 year of age or younger	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is Minnesota Department of Commerce at 1 800-657-3602; the 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 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. 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.mnsure.org or call 1-855-366-7873.

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 on how 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 at 1-866-873-5943; Minnesota Department of Commerce at 1 800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, Service Cooperative, or church plan, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copay	$60
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$20
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,280**

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

The plan's overall deductible	$1,500
Specialist copay	$60
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,680**

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus - M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

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

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒိး. တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစ၊ၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်. ကိး 711 တက့၊်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.