CHI BENEFITS

Summary of Benefits Coverage

Integrated Basic – Blue Cross Blue Shield of Illinois

Effective January 1, 2015

The following is an overview of your Catholic Health Initiatives **Integrated Basic** medical plan option for 2015. If approved, you may be eligible for the Health Care Assistance Program. For details about how the Health Care Assistance Program works with the Integrated Basic medical plan option, log on to Inside CHI at http://home.catholichealth.net.

The Accountable Care Act (also known as Health Care Reform) requires employers to provide the enclosed summary of medical benefits for all of the medical plan options available. You do not need to take action. Carefully review the following summary of benefits coverage and file it away for future reference. If you have questions or would like additional detail about the medical plan, refer to your Summary Plan Description (SPD).

CHI Healthy SPIRIT
Physical and financial health and wellness

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This is only a summary. For more detail about your coverage and costs, you can get the complete terms in the policy or plan document (SPD) by calling the HR/Payroll Connection Support Center at 1-888-450-9450 or contacting your local HR leader. If you have access to My Healthy Spirit, log on to http://home.catholichealth.net/myhealthyspirit select the Benefits tab, then select the View or Print Summary Plan Descriptions link for additional details. If you do not have access to My Healthy Spirit, go to http://chibenefitplans.net to view your SPD.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Clinically Integrated Network** $2,000 Individual / $4,000 Family **BC/BS Network** $2,000 Individual / $4,000 Family **Out-of-network** $4,000 Individual / $8,000 Family Copayments, preventive care, office visits, CHI facility charges and prescription drugs do not apply toward the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document (Summary Plan Description) to see when the deductible starts over (usually January 1st). See the chart starting on the next page for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	There are no other specific deductibles.
Is there an out–of–pocket limit on my expenses?	**Clinically Integrated Network and BC/BS Network combined** $4,000 Individual / $8,000 Family **Out-of-network** $12,000 Individual / $24,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and penalties/ineligible charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on the next page describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, go to www.bcbsil.com/chi or call 1-866-776-4244. CHI Memorial employees in Chattanooga use the S network (BC/BS of TN network).	If you use an in-network provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart on the next page for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed later in this document. See your plan document (Summary Plan Description) for details about excluded services.

- **Copayments** are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Blue Cross Blue Shield of Illinois **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. Note: CHI Memorial employees in Chattanooga use the S network (BC/BS of TN network).

Common Medical Event	Services You May Need	Your Cost If You Use a Clinically Integrated Network Provider	Your Cost If You Use a BC/BS Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	30% coinsurance (no deductible)	60% coinsurance after deductible	Any service bundled with your office visit and billed as part of the office visit is not subject to the deductible and coinsurance. Providers must be in the local clinically integrated network to receive the higher benefit. Acupuncture is limited to 10 visits per year. Chiropractic care is limited to 20 visits per year. Massage, occupational, physical and speech therapies have a combined therapy limit of 30 visits per year; CHI facilities are not subject to the 30-visit limit.
	Specialist visit	$35 copayment	35% coinsurance (no deductible)	60% coinsurance after deductible	
	Other practitioner office visit	15% coinsurance after deductible	35% coinsurance after deductible	60% coinsurance after deductible	
	Preventive care/screening/ immunization	$0	$0	$0	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	If a test is performed during your office visit and billed as part of the office visit, then it is considered a part of the office visit coinsurance. If the test is sent to a third party for analysis, the charges for the analysis do not fall under the office visit but would be subject to the deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Clinically Integrated Network Provider	Your Cost If You Use a BC/BS Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $5 copay Mail Order: $10 copay (no deductible)	Retail: $10 copay Mail Order: $20 copay (no deductible)	Retail: 60% coinsurance Mail Order: N/A	Covers up to a 30-day supply from an in-network retail pharmacy or a 90-day supply from the Caremark mail order pharmacy. If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name coinsurance plus the difference between the generic and brand-name. Maintenance medications must be filled using the mail order pharmacy or a CHI-owned pharmacy. Diabetic insulin and syringes purchased at a network retail pharmacy on the same day are subject to one copayment/coinsurance amount. Additional copayment/ coinsurance amount will apply to additional diabetic supplies purchased on the same day.
	Preferred brand drugs	15% coinsurance Retail: $17.50 min/$50 max Mail Order: $42.50 min/$75 max	30% coinsurance Retail: $35 min/$100 max Mail Order: $85 min/$150 max	Retail: 60% coinsurance Mail Order: N/A	
	Non-preferred brand drugs	25% coinsurance Retail: $30 min/$75 max Mail Order: $75 min/$150 max	50% coinsurance Retail: $60 min/$150 max Mail Order: $150 min/$300 max	Retail: 60% coinsurance Mail Order: N/A	
	Specialty drugs	Refer to above costs	Refer to above costs	Refer to above costs	Some specialty drugs may not be available at a retail pharmacy, but can be filled through the mail order pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance (no deductible)	35% coinsurance after deductible	60% coinsurance after deductible	None
	Physician/ surgeon fees	15% coinsurance after deductible	35% coinsurance after deductible	60% coinsurance after deductible	None
If you need immediate medical attention	Emergency room services	$150 copay (waived if you are admitted)	$150 copay (waived if you are admitted)	$150 copay (waived if you are admitted)	Non-emergency use of the ER will require 50% coinsurance after deductible.
	Emergency medical transportation	$0	$0	$0	Benefits will not be provided for long distance trips or for non-medically necessary use of an ambulance, including use because it is more convenient than other transportation.

Common Medical Event	Services You May Need	Your Cost If You Use a Clinically Integrated Network Provider	Your Cost If You Use a BC/BS Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Urgent care	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	The cost you pay will depend on how the facility bills the insurance. For purposes of this summary, we are assuming the urgent care would be billed as an outpatient fee.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance (no deductible)	35% coinsurance after deductible	60% coinsurance after deductible	Inpatient hospital stays must be pre-certified through Blue Cross Blue Shield of Illinois. There is a $500 penalty for failure to pre-certify.
	Physician/surgeon fee	15% coinsurance after deductible	35% coinsurance after deductible	60% coinsurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance (no deductible)	35% coinsurance (no deductible)	60% coinsurance after deductible	None
	Mental/Behavioral health inpatient services	15% coinsurance (no deductible)	35% coinsurance (no deductible)	60% coinsurance after deductible	Inpatient hospital stays must be pre-certified through Blue Cross Blue Shield of Illinois. There is a $500 penalty for failure to pre-certify.
	Substance use disorder outpatient services	15% coinsurance (no deductible)	35% coinsurance (no deductible)	60% coinsurance after deductible	None
	Substance use disorder inpatient services	15% coinsurance (no deductible)	35% coinsurance (no deductible)	60% coinsurance after deductible	Inpatient hospital stays must be pre-certified through Blue Cross Blue Shield of Illinois. There is a $500 penalty for failure to pre-certify.
If you are pregnant	Prenatal and postnatal care	$20 copayment	30% coinsurance (no deductible)	60% coinsurance after deductible	The first prenatal visit, if billed separate, should be covered 100 percent as a preventive benefit.
	Delivery and all inpatient services	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	Maternity stay at the hospital must be pre-certified through Blue Cross Blue Shield of Illinois. There is a $500 penalty for failure to pre-certify.

Common Medical Event	Services You May Need	Your Cost If You Use a Clinically Integrated Network Provider	Your Cost If You Use a BC/BS Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	Home health care must be pre-certified through Blue Cross Blue Shield of Illinois.
	Rehabilitation services	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	None
	Habilitation services	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	None
	Skilled nursing care	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	Skilled nursing services must be pre-certified through Blue Cross Blue Shield of Illinois. Skilled nursing room and board are not covered by the plan.
	Durable medical equipment	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	None
	Hospice service	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	None
If your child needs dental or eye care	Eye exam	$20 copayment	30% coinsurance	60% coinsurance after deductible	Limited to eye exams for the purpose of diagnosing a medical condition (such as diabetes) and assuming it is billed as an office visit. Routine eye exams for newborns and children are covered when billed as part of a well-child visit.
	Glasses	15% coinsurance (deductible applies for all physician charges)	35% coinsurance after deductible	60% coinsurance after deductible	Benefits are only provided for the first pair of eyeglasses needed after cataract surgery, cornea transplantation or cornea grafting.
	Dental check-up	N/A	N/A	N/A	Diagnostic and preventive dental services are not covered under the CHI Medical Plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care outside of the U.S.
- Routine eye care (Adult & Child)

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Acupuncture (up to 10 visits per year)
- Bariatric surgery (if approved); limitations apply
- Chiropractic care (up to 20 visits per year)
- Specific fertility treatment ($15,000 lifetime maximum per person) and fertility prescription drugs ($5,000 lifetime maximum per person); limitations apply
- Private-duty nursing (must be pre-certified through Blue Cross Blue Shield of Illinois)
- Routine foot care (if medically necessary)
- Weight loss programs (provided by Preventure)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, federal and state laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may apply. For more information on your rights to continue coverage, contact HR/Payroll Connection at 1-888-450-9450. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or visit www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross Blue Shield at 1-866-776-4244 or Caremark (for prescription) at 1-877-232-7925 or Department of Labor's Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Para obtener asistencia en Español, llame al 1-888-450-9450.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,515
- **Patient pays** $4,025

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (2 generic)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles (assumes individual coverage level)	$2,000
Copays (2 generic prescriptions)	$20
Coinsurance (assumes non-CHI facility within the BC/BS network)	$1,855
Limits or exclusions (over-the-counter prenatal vitamins)	$150
Total	**$4,025**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,780
- **Patient pays** $2,620

Sample care costs:

Prescriptions (40 generic)	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles (assumes individual coverage)	$2,000
Copays (40 generic prescriptions)	$400
Coinsurance (assumes non-CHI facility within the BC/BS network)	$140
Limits or exclusions (over-the-counter supplies)	$80
Total	**$2,620**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.