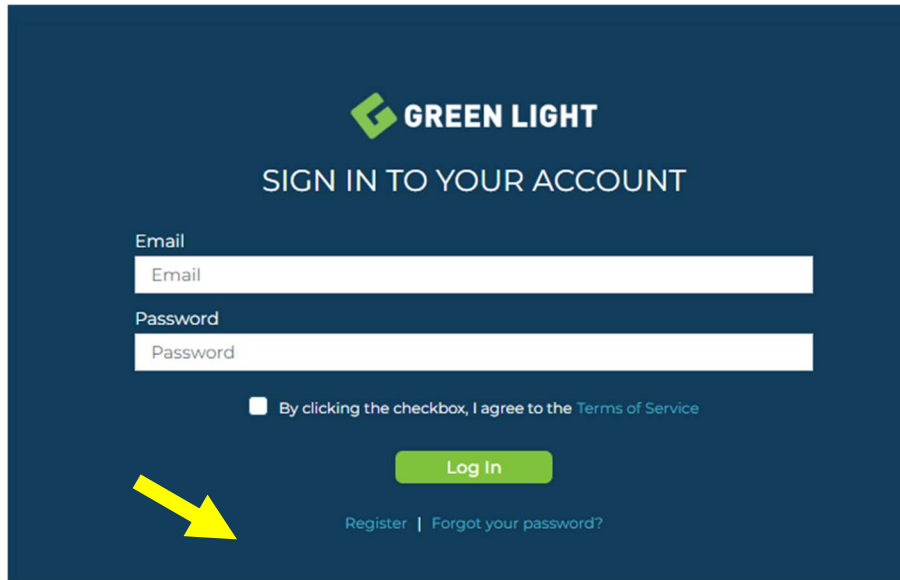


Green Light Steps to Register

1. Go to www.mycostestimates.com.
2. On the home page, select "Register".



GREEN LIGHT

SIGN IN TO YOUR ACCOUNT

Email
Email

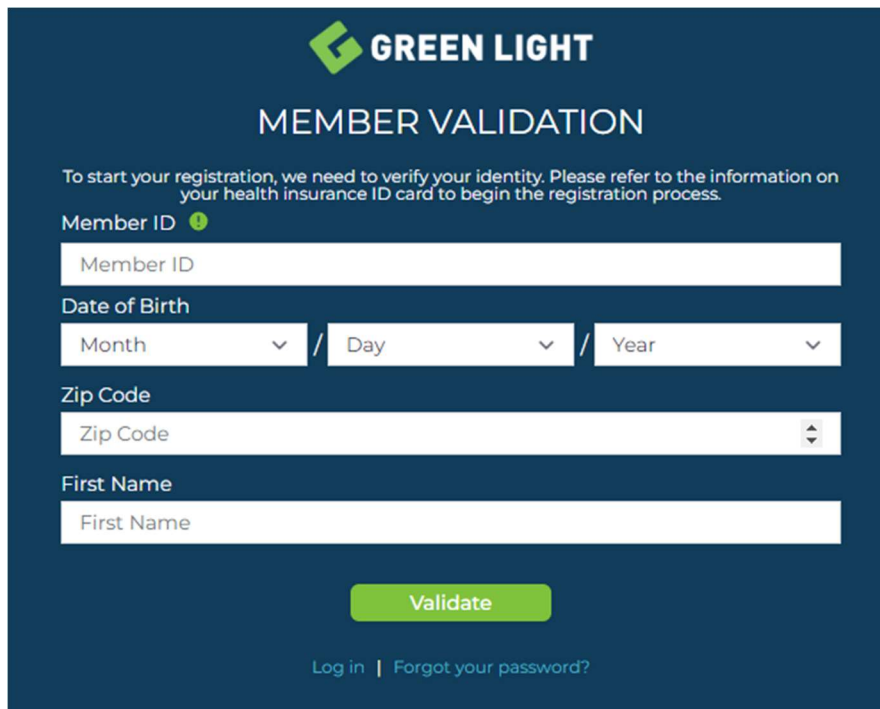
Password
Password

By clicking the checkbox, I agree to the [Terms of Service](#)

[Log In](#)

[Register](#) | [Forgot your password?](#)

3. Then Complete the "Member Validation" section and select "Validate".



GREEN LIGHT

MEMBER VALIDATION

To start your registration, we need to verify your identity. Please refer to the information on your health insurance ID card to begin the registration process.

Member ID ⓘ

Member ID

Date of Birth

Month / Day / Year

Zip Code

Zip Code

First Name

First Name

[Validate](#)

[Log in](#) | [Forgot your password?](#)

4. Then you will be directed to the “Member Registration” page, where you will enter your email address and create a password. Once this is completed, select “Register”.

GREEN LIGHT

MEMBER REGISTRATION

Success!
Welcome, [redacted]

Email
[input field]

Password
[input field]

Confirm Password
[input field]

Your password must include the following:

- Be at least 12 characters long
- Include at least one lower case letter (a-z)
- Include at least one upper case letter (A-Z)
- Include at least one number or special character (0-9, @#\$%&!)

By clicking the checkbox, I agree to the [Terms of Service](#)

Register

[Member Validation](#) | [Log in](#) | [Forgot your password?](#)

5. You will receive an email to “Complete My Registration” and this will confirm your account to be able to log in.

CONFIRM YOUR REGISTRATION

Welcome

Thank you for registering for access to the Price Comparison Tool.

To confirm your account, please click the link below.

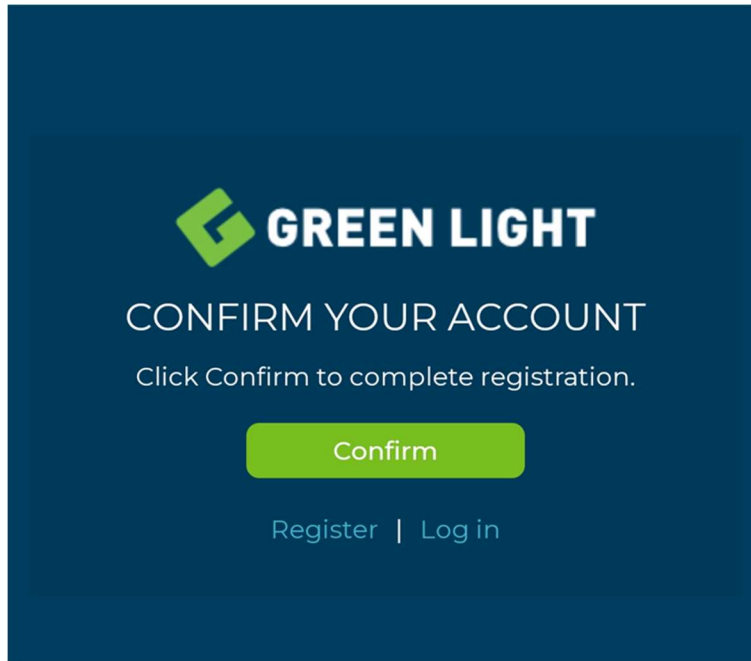
[Complete My Registration](#)

If you did not register, please ignore this message.

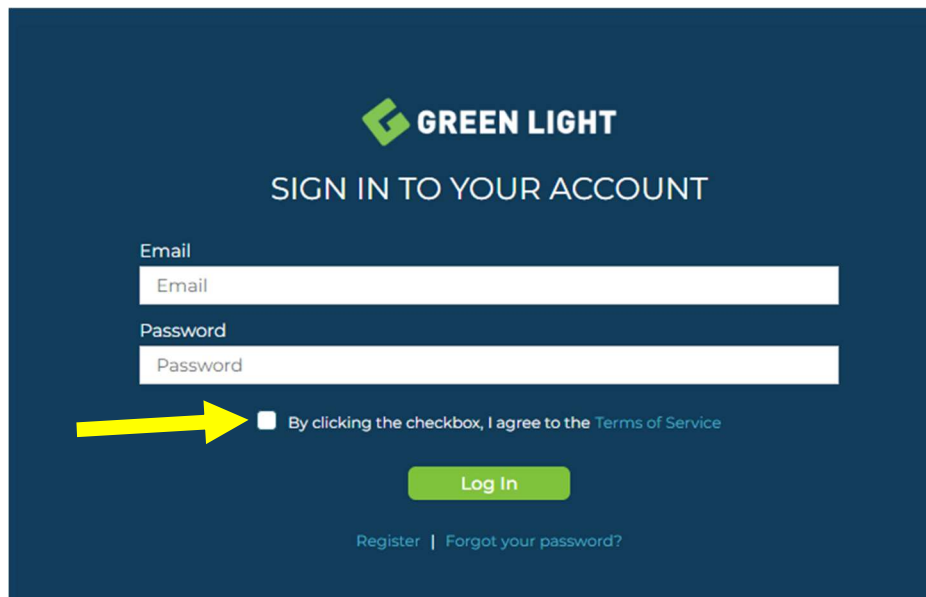
Thank you,

Green Light

6. Once you select “Complete My Registration”, you will be directed to Green Light to “Confirm” your registration.



7. Once you confirm your registration, you are then re-directed to the Log In page – where you can enter your email and password – you must check the checkbox to agree to the Terms of Service before you will be allowed to log in.



- Once you log in, you will be directed to your home page. Here you can review your in-network and out-of-network benefits – including Plan Limitations and Plan Provisions

Welcome Kerry!

PRICE COMPARISON TOOL

The price comparison tool is designed to provide you with real-time estimates of your cost-sharing liability for health care items and services from different providers. This estimated cost-sharing information allows you to understand how cost-sharing for covered health care items and services is determined by your health plan and allows you to shop and compare health care costs before receiving care. This tool supports the initial list of 500 shoppable services as required by federal regulations for plan years beginning on or after January 1, 2023. The remainder of all items and services will be supported for plan years beginning on or after January 1, 2024.

Network: BlueCross and BlueShield of Illinois Client: SMART Local No 265-Health and Welfare Fund Plan: Plan A For Union And Fund Office Employees Search Location: Worth, IL 60482 [Change](#)

MEMBER SELECTION

Select an Individual:

YOUR IN-NETWORK BENEFITS

	Individual	Family
Deductible:	\$500.00	\$1,000.00
Out Of Pocket:	\$3,000.00	\$6,000.00

Coinsurance: The percentage of the allowed amount your plan will pay for in-network providers after your deductible and copays (if applicable)

	Plan Pays	You Pay
Inpatient Hospital:	80.00%	20.00%
Primary Care Physician:	80.00%	20.00%
Physician Specialist:	80.00%	20.00%
Urgent Care:	80.00%	20.00%
Emergency Room:	80.00%	20.00%
Laboratory and Diagnostic Radiology:	80.00%	20.00%
Durable Medical Equipment:	80.00%	20.00%

Copay: The amount that you will be charged by the provider at the time services are rendered

	Copay
Inpatient Hospital:	N/A
Primary Care Physician:	N/A
Physician Specialist:	N/A
Urgent Care:	N/A

YOUR OUT-OF-NETWORK BENEFITS

	Individual	Family
Deductible:	\$1,000.00	\$2,000.00
Out Of Pocket:	\$6,000.00	\$12,000.00

Coinsurance: The percentage of the allowed amount your plan will pay for out-of-network providers after your deductible and copays (if applicable)

	Plan Pays	You Pay
Inpatient Hospital:	60.00%	40.00%
Primary Care Physician:	60.00%	40.00%
Physician Specialist:	60.00%	40.00%
Urgent Care:	60.00%	40.00%
Emergency Room:	60.00%	40.00%
Laboratory and Diagnostic Radiology:	60.00%	40.00%
Durable Medical Equipment:	60.00%	40.00%

Copay: The amount that you will be charged by the provider at the time services are rendered

	Copay
Inpatient Hospital:	N/A
Primary Care Physician:	N/A
Physician Specialist:	N/A
Urgent Care:	N/A

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PLAN LIMITATIONS / OTHER PLAN PROVISIONS +

- Under your name, you can update your settings or sign out.

- You can begin your search by updating your “Search Location”.

Search Location:

Change

11. Then you will select a member in the “Member Selection”.

MEMBER SELECTION

Select an Individual:

- Kerry
- Jack
- Cailla

PROVIDER SEARCH

12. Then under the Provider Search, you will update how far you are willing to travel for services.

PROVIDER SEARCH

Distance:

- How far are you willing to travel?
- 5 miles
- 10 miles
- 15 miles
- 20 miles
- 25 miles
- up to 100 miles

13. Then you will search your health care item or service by either the procedure code or by description of the service.

PROVIDER SEARCH

Distance:

5 miles

Service Type:

- Select..
- Search by code
- Search by description

14. Once this section is completed, it will look like this and then you can search for your service.

PROVIDER SEARCH

Distance:

5 miles

Service Type:

Search by code

Search Service:

ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME X

Search

Results:

Code: 81528

Code Type: CPT

Description:

ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME TARGET AND SIGNAL AMPLIFICATION OF 10 DNA MARKERS (KRAS MUTATIONS, PROMOTER METHYLATION OF NDRG4 AND BMP3) AND FECAL HEMOGLOBIN, UTILIZING STOOL, ALGORITHM REPORTED AS A POSITIVE OR NEGATIVE RESULT

Plain Language Description:

Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

15. Before Green Light will give you the cost estimate, you are required to review the Transparency in Coverage Notice. Once you have reviewed the notice, you are required to select “I Understand” to continue onto the cost estimate.

TRANSPARENCY IN COVERAGE NOTICE

PLAN A FOR UNION AND FUND OFFICE EMPLOYEES

02/2/2024

You are receiving this notice because you requested a cost estimate for an item or service. This notice contains important information about the cost estimate and information on the amount you may be required to pay for this item or service.

I. THE BASICS

What should I do with this notice?

Read this notice carefully along with the cost estimate. You may need to request a new cost estimate as you obtain new information, such as information on additional items or services you will receive as part of your diagnosis, treatment, or procedure.

What are the key terms?

1. An **Allowed Amount** is the maximum amount your health plan will pay for a covered item or service furnished by an out-of-network provider.
2. **Cost Sharing** is your share of costs for a covered item or service that you must pay (sometimes called “out-of-pocket costs”). Some examples of cost sharing are deductibles, coinsurance, and copayments. This term does not include other costs you may be responsible for, such as premiums, balance-billed amounts for out-of-network providers, or the cost of items or services not covered by your health plan.
3. An **Accumulated Amount** is the amount of financial responsibility you have incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit.
4. A **Covered Item or Service** is an item or service that your health plan will pay for, either in whole or in part, under the terms of your health plan.
5. An **Out-of-Network Provider** is a provider that does not have a contract with your plan to provide the requested items or services at pre-negotiated rates.
6. **Prerequisites** are certain requirements your health plan may impose on you or your provider so that your plan can determine whether a health care item or service, including treatment plans, prescription drugs, or durable medical equipment, is medically necessary before your plan will provide benefits for these items and services. For purposes of this estimate, prerequisites include prior authorization, concurrent review, and step-therapy or fail-first requirements.

Other common medical and insurance terms, including definitions of deductibles, coinsurance, and copayments, can be found in the [Uniform Glossary of Coverage and Medical Terms](#)

II. IMPORTANT INFORMATION ABOUT YOUR COST ESTIMATE

This estimate is designed to provide you with information about the cost of an item or service before you receive care. However, this estimate has certain limitations that you should consider before making any decision to receive the item or service.

1. If you are treated by an out-of-network provider, after paying the cost-sharing amount determined by your health plan, you may still receive a bill for the difference between the amount the out-of-network provider charges for the item or service and the amount paid by your health plan for that same item or service. This is called balance billing, and this amount is not included in your cost estimate.
2. The actual charge for the item or service may be different than the cost estimate, depending on the actual care you receive. For example, if your physician provides additional services during your visit, your charges could be more than the cost estimate. This is one reason why it is important to discuss with your provider both before and during your visit which items and services you will receive and to request a new cost estimate if new information becomes available.
3. This cost estimate is not a benefit determination or guarantee of coverage for the item or service for which you requested information. For example, your plan may need to determine whether the item or service is medically necessary in your case before making a payment. You should follow your health plan’s process for filing a claim for benefits and contact your health plan to help determine if there are any additional requirements that apply to you as part of that process.
4. Your health plan does not count copayment assistance and other third-party payments in the calculation of your accumulated amounts (such as deductible and out-of-pocket maximum amounts).
5. An in-network item or service may not be subject to cost sharing if it is billed as a preventive service.

III. PREREQUISITES

- a. **Prior Approval**
In some scenarios including inpatient stays, surgeries, cancer treatments etc., your health plan must decide whether this item or service is medically necessary before it will cover this item or service. This is called prior approval. Your health plan may impose additional costs if you or your provider do not submit this item or service for prior approval before the item or service is provided. Please use the contact information provided below if you have any question on whether or not this service requires prior approval.
- b. **Concurrent Review**
Your health plan may require a review during an ongoing course of treatment to determine whether the plan will continue to cover the item or service. This is called concurrent review. Your health plan may cease covering treatment if you or your provider do not submit this item or service for concurrent review within a specified time period after beginning your treatment or procedure.
- c. **Step-therapy**
Your health plan will not pay for higher-cost therapies without evidence that certain lower-cost therapies have not been effective for you (these are known as fail-first policies or step-therapy requirements). You may be required to try a lower-cost alternative before your plan will cover this particular item or service.

IV. WHAT IF I NEED MORE INFORMATION?

Please Contact:

SMART Local No 265 Health and Welfare Fund
(630) 668-7260
Benefits@SMART265funds.org

For additional information, please visit <https://www.SMART265funds.org/welfare>

16. Your search results will look like this.

GREEN LIGHT Kerry

New Search Contact Us About

IN-NETWORK In-Network Out-of-Network

BLUECROSS AND BLUESHIELD OF ILLINOIS

Member Name: Kerry
Code: 81528
Code Type: CPT
Radius: 5 miles

Description: Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result.

Plain Language Description: Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result.

Payer: SMART Local No 265 Health and Welfare Fund Phone: (630) 668-7260 Email: Benefits@SMART265funds.org Website: <https://www.SMART265funds.org/welfare>

DISCLAIMER: Not all of the providers listed below may be available on the date you would like to have the procedure OR they may not perform the procedure you are researching.

Showing 1 to 17 of 17 results Sort By: Mileage 1

American Medical Lab Clinical Medical Laboratory 10604 Southwest Hwy Ste 106b Chicago Ridge, IL 60415 (708) 926-2116 1.1 miles BlueCross and BlueShield of Illinois Contractual Allowance \$519.95 Your Estimated Responsibility \$503.99	Express Medical Labs Llc Clinical Medical Laboratory 9830 Ridgeland Ave Ste 115 Chicago Ridge, IL 60415 (708) 336-9002 1.1 miles BlueCross and BlueShield of Illinois Contractual Allowance \$519.95 Your Estimated Responsibility \$503.99	Rt Pcr Test Near Me Inc Clinical Medical Laboratory 7000 Southwest Hwy Ste 105 Chicago Ridge, IL 60415 (773) 791-4363 1.1 miles BlueCross and BlueShield of Illinois Contractual Allowance \$519.95 Your Estimated Responsibility \$503.99
Aqsa Lab Inc Clinical Medical Laboratory 10322 S Harlem Ave Palos Hills, IL 60465 (708) 576-8881 1.9 miles	Stat Laboratory Inc Clinical Medical Laboratory 10714 S Roberts Rd Ste A Palos Hills, IL 60465 (708) 608-8948 1.9 miles	Palos Community Hospital General Acute Care Hospital 12251 S 80th Ave Palos Heights, IL 60463 (708) 361-4500 2.0 miles

17. From here you can sort your search and switch between in-network and out-of-network.

Sort By: Mileage

- Mileage
- Provider Name
- Medical Specialty
- Contractual Allowance
- Estimated Responsibility
- MIPS Score

Rt Pcr Test Near Me Inc
Clinical Medical Laboratory
7000 Southwest Hwy Ste 105
Chicago Ridge, IL 60415
(773) 791-4363

Kerry

New Search Contact Us About

In-Network Out-of-Network

18. You can get additional benefit details by selecting the magnifying glass.

American Medical Lab
Clinical Medical Laboratory

10604 Southwest Hwy Ste 106b
Chicago Ridge, IL 60415
(708) 926-2116

1.1 miles

BlueCross and BlueShield of Illinois

Contractual Allowance **\$519.95**

Your Estimated Responsibility \$503.99

19. When you select the magnifying glass, you will see a Benefit Explanation. This breaks down the charge, showing you what your estimated responsibility and your accumulations on what has been satisfied on the deductibles and out-of-pocket maximums.

BENEFITS EXPLANATION

The contractual allowance for service code 81528 is \$519.95.

Please be aware that the provider may bill different healthcare service codes and/or additional healthcare service codes, which may affect your cost sharing amounts. In the event your payer determines that this is a preventive health service, your estimated responsibility may be reduced to \$0. Any amounts you pay at the time of service will be applied to your estimated cost sharing amounts.

Required Cost Sharing	Individual Accumulated Amount			Family Accumulated Amount		
	Required	Met	Remaining	Required	Met	Remaining
In-Network Deductible	\$500.00	\$0.00	\$500.00	\$1,000.00	\$500.00	\$500.00
Out-of-Network Deductible	\$1,000.00	\$0.00	\$1,000.00	\$2,000.00	\$0.00	\$2,000.00
In-Network Out-of-Pocket Maximum	\$3,000.00	\$0.00	\$3,000.00	\$6,000.00	\$27.20	\$5,972.80
Out-of-Network Out-of-Pocket Maximum	\$6,000.00	\$0.00	\$6,000.00	\$12,000.00	\$0.00	\$12,000.00

Your Estimated Responsibility	Amount
Contractual Allowance	\$519.95
Your Copay	\$0.00
Your In-Network Deductible	\$500.00
Amount Eligible for Benefits	\$19.95
Your Coinsurance	20% \$3.99
Your Health Plan Pays	80% \$15.96
Your Estimated Responsibility	\$503.99

20. If you select the “Out-of-Network” tab, you will get the results of seeing an out-of-network provider – along with information on how these claims are considered. You select the magnifying glass for additional details.

GREEN LIGHT Kerry

New Search Contact Us About

OUT-OF-NETWORK

In-Network Out-of-Network

Member Name: Kerry
Code: 81528
Code Type: CPT
Radius: 5 miles

Description: Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

Plain Language Description: Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

Payer: SMART Local No 265 Health and Welfare Fund
Phone: (630) 668-7260
Email: Benefits@SMART265funds.org
Website: <https://www.SMART265funds.org/welfare>

Your health plan calculates the allowance for out-of-network providers at

For non-PPO network providers, the acceptable R&C Charge is determined by uniform reference standards as adopted by the Board of Trustees. The R&C Charge for non-PPO network providers will be 100% of the Medicare reimbursement rates for the services provided. The Allowable Charge for non-PPO ambulance service providers is 80% of 300% of the Medicare allowance. Medically necessary air ambulance services are subject to fee review.

Your Estimated Responsibility **\$0.00**

PLEASE NOTE: If you are treated by an out-of-network provider, after paying the cost-sharing amount determined by your health plan, you may still receive a bill for the difference between the amount the out-of-network provider charges for the item of service and the amount paid by your health plan for that same item or service. This is called balance billing, and this amount is not included in your cost estimate.

BENEFITS EXPLANATION

Required Cost Sharing	Individual Accumulated Amount			Family Accumulated Amount		
	Required	Met	Remaining	Required	Met	Remaining
In-Network Deductible	\$500.00	\$0.00	\$500.00	\$1,000.00	\$500.00	\$500.00
Out-of-Network Deductible	\$1,000.00	\$0.00	\$1,000.00	\$2,000.00	\$0.00	\$2,000.00
In-Network Out-of-Pocket Maximum	\$3,000.00	\$0.00	\$3,000.00	\$6,000.00	\$27.20	\$5,972.80
Out-of-Network Out-of-Pocket Maximum	\$6,000.00	\$0.00	\$6,000.00	\$12,000.00	\$0.00	\$12,000.00

Your Estimated Responsibility	Amount
Out-of-Network Allowance	\$0.00
Your Copay	\$0.00
Your Out-of-Network Deductible	\$1,000.00
Amount Eligible for Benefits	\$0.00
Your Coinsurance	40% \$0.00
Your Health Plan Pays	60% \$0.00
Your Estimated Responsibility	\$0.00

21. And if you need to start a new search, just select the “New Search” tab at the top of the screen.

Kerry

New Search Contact Us About