

 **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](http://www.bcbsil.com) or by calling 1-855-705-7279. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For <u>In-Network</u> : \$2,500 Individual/\$5,000 Family For <u>Out-of-Network</u> : \$2,500 Individual/\$5,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> , and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <u>In-Network</u> : \$6,000 Individual/\$12,000 Family For <u>Out-of-Network</u> : \$11,200 Individual/\$22,400 Family <u>Prescription drug</u> expense limit: \$1,000 Individual/\$2,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-855-705-7279 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copay</u> applies to office visit only. Virtual visits, \$10 <u>copay</u> applies.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Certain women's <u>preventive services</u> will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. You may have to pay for services that aren't preventive. Ask your <u>Provider</u> if the services needed are preventive. Then check what your <u>Plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 800-432-1973	Generic drugs	\$15 <u>copay</u> /prescription (retail) \$30 <u>copay</u> /prescription (mail order); <u>Deductible</u> does not apply	<u>In-Network</u> payment minus applicable <u>copay</u> .	Rx out-of-pocket expense limit: \$1,000 Individual / \$2,000 Family 30-day supply at retail; 90-day supply at retail or mail order If a generic equivalent is available, you will pay the cost difference between the brand and generic plus the <u>copay</u> . For <u>Out-of-Network</u> drug provider, you are responsible for 25% of the eligible amount after the <u>copayment</u> or <u>coinsurance</u> .
	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail) \$60 <u>copay</u> /prescription (mail order); <u>Deductible</u> does not apply	<u>In-Network</u> payment minus applicable <u>copay</u> .	
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription (retail) \$100 <u>copay</u> /prescription (mail order); <u>Deductible</u> does not apply	<u>In-Network</u> payment minus applicable <u>copay</u> .	
	<u>Specialty drugs</u>	Applicable <u>copay</u> applies	<u>In-Network</u> payment minus applicable <u>copay</u> .	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Emergency room: \$150 <u>copay</u> Emergency room services: 10% <u>coinsurance</u>	Emergency room: \$150 <u>copay</u> Emergency room services: 10% <u>coinsurance</u>	Inpatient <u>copay</u> applies if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150 <u>copay</u> per admission plus 40% <u>coinsurance</u>	The admission <u>copay</u> applies to the first 5 Inpatient admissions. <u>Preauthorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$30 PCP <u>copay</u> applies to psychotherapy office visit only. Virtual visits, \$10 <u>copay</u> applies. <u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Inpatient services	\$150 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150 <u>copay</u> per admission plus 40% <u>coinsurance</u>	The admission <u>copay</u> applies to the first 5 Inpatient admissions. <u>Preauthorization</u> required.
<b>If you are pregnant</b>	Office visits	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copay</u> applies to first prenatal visit (per pregnancy).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost Sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$150 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150 <u>copay</u> per admission plus 40% <u>coinsurance</u>	The admission <u>copay</u> applies to the first 5 Inpatient admissions.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 visits per benefit period. <u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 visits combined per benefit period for occupational therapy, speech therapy and physical therapy. <u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$150 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150 <u>copay</u> per admission plus 40% <u>coinsurance</u>	Limited to 60 days per benefit period. The admission <u>copay</u> applies to the first 5 Inpatient admissions. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to a 180 day maximum per lifetime. <u>Preauthorization</u> may be required.
<b>If your child needs dental or eye care</b>	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:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and children)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Routine eye care (Adult and children)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (with the exception of those with diabetes)</li> </ul>

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (Limited to 35 visits per benefit period)
- Hearing aids (1 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (excluding inpatient private duty nursing)
- Weight loss programs (except when non-medically supervised)

**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 1-888-979-4516, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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 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 and Blue Shield of Illinois at 1-888-979-4516 or visit [www.bcbsil.com](http://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](http://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**

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 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 1-888-979-4516.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-979-4516.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-979-4516.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-979-4516.

*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)

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	\$50
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,760</b>

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

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	\$50
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

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

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	\$50
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</b>

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

### Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. 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. 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  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

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  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>  
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

#### To receive language or communication assistance free of charge, please call us at 855-710-6984.

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	જો તમને ભાષા અથવા સંચારની મદદની જરૂર છે તો કૃપા કરીને 855-710-6984 નંબર પર કોલ કરો.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
□□□	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1 haz'1. 1-866-560-4042 j8 hod7lni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.