
 **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 or by calling 1-800-458-6024. 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: |
|--|---|---|
| What is the overall deductible? | For <u>In-Network</u> : \$500 Individual / \$1,500 Family For <u>Out-of-Network</u> : \$1,500 Individual / \$4,500 Family <u>Copays</u> don't count toward the deductible. | 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> . |
| Are there services covered before you meet your deductible? | Yes. Certain <u>preventive care</u> , <u>prescription drugs</u> , and emergency room services 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 www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | For <u>In-Network</u> : \$2,000 Individual / \$6,000 Family For <u>Out-of-Network</u> : \$6,000 Individual / \$18,000 Family Prescription drug expense limit: \$5,150 Individual/ \$8,300 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. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing charges</u> , 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> . |
| Will you pay less if you use a network provider? | Yes. For a list of <u>In-Network Providers</u> , visit www.bcbsil.com or call 1-800-458-6024. | 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 charge</u> and what your <u>plan</u> pays (<u>balance</u> |

| Important Questions | Answers | Why This Matters: |
|--|---------|---|
| | | billing). 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. |
| Do you need a referral to see a specialist? | 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 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% <u>coinsurance</u> | 40% <u>coinsurance</u> | Virtual Visits (Telehealth) covered at the <u>In-Network Provider</u> level per visit by a Designated Virtual <u>Network Provider</u> . No Virtual Coverage <u>out-of-network</u> . |
| | <u>Specialist visit</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge; <u>deductible</u> does not apply. | 40% <u>coinsurance</u> | 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. |
| If you have a test | <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> | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or 1-800-711-0917 | Generic drugs | \$15 <u>copay</u> / retail \$20 <u>copay</u> / mail order | Not Covered | RX Out-of-Pocket Expense Limit: \$5,150 Individual/\$8,300 Family Retail 30 day supply. Mail order 90 day supply. Prior authorization may be required. |
| | Preferred brand drugs | \$25 <u>copay</u> / retail \$35 <u>copay</u> / mail order | Not Covered | |
| | Non-preferred brand drugs | \$45 <u>copay</u> / retail \$50 <u>copay</u> / mail order | Not Covered | |
| | <u>Specialty drugs</u> | \$30 <u>copay</u> / retail \$35 <u>copay</u> / mail order | Not Covered | |
| If you have outpatient surgery | 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 |

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

| 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 need immediate medical attention | Emergency room care | \$150 copay/visit | \$150 copay/visit | Copay waived if admitted to the hospital. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details. |
| | Urgent care | 20% coinsurance | 40% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 40% coinsurance | Preauthorization may be required; see your benefit booklet* for details. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| If you are pregnant | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

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

| 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 need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 70 visits per calendar year for Occupational therapy. 50 visits per calendar year for Speech therapy. 115 visits calendar year for Physical therapy. Preauthorization may be required. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | |
| | Children's dental check-up | Not Covered | Not Covered | |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult and Children)
- Long-term care
- Routine eye care (Adult and Children)
- Routine foot care (with exception of those diagnosed with diabetes)

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
- Hearing aids (1 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of 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 1-800-458-6024, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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 1-800-458-6024 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

Does this plan provide Minimum Essential Coverage? Yes

[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 1-800-458-6024.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-6024.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-458-6024.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-458-6024.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

| | |
|--|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,060 |

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

| | |
|--|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
 Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$300 |
| <i>What isn't covered</i> | |
| 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 | \$500 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,000 |

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., 35th 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.

Table with 2 columns: Language and Assistance Description. Rows include Español, العربية, 繁體中文, Français, Deutsch, ગુજરાતી, हिन्दी, Italiano, Navajo, فارسی, Polski, Русский, Tagalog, اردو, and Tiếng Việt.