

 **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.bcbst.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?	\$250 Individual/\$750 Family	Generally, you must pay all of the costs from providers 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> is covered before you meet your deductible.	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.
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> : \$500 Individual/\$1,500 For <u>Out-of-Network</u> : \$2,500 Individual/\$7,500 Family RX Out-of-Pocket Expense Limit: \$7,400 Individual / \$14,300 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</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> .
Will you pay less if you use a network provider?	Yes. See www.bcbst.com or call 1-800-458-6024 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 charge</u> 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.
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 Providers (You will pay the least)	Out-of-Network Providers (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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Specialist visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Preventive care/screening/immunization	No Charge; deductible does not apply	30% <u>coinsurance</u>	Certain women's preventive services will be covered with no cost to the member. For a full list of these services, please contact BCBS 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Coinsurance</u> may vary if services rendered in an outpatient hospital setting.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com	Generic drugs	Retail: \$10 <u>copay</u> Mail Order: \$20 <u>copay</u>	Retail: \$10 <u>copay</u>	Covers up to a 34-day supply for retail prescriptions or up to a 90 day supply for mail order prescriptions. RX Out-of-Pocket Expense Limit: \$7,400 Individual / \$14,300 Family.
	Preferred brand drugs	Retail: \$20 <u>copay</u> Mail Order: \$40 <u>copay</u>	Retail: \$20 <u>copay</u>	
	Non-preferred brand drugs	Retail: \$40 <u>copay</u> Mail Order: \$80 <u>copay</u>	Retail: \$40 <u>copay</u>	
	Specialty drugs	Various <u>copayments</u> may apply.	Not Covered	Covered at the applicable <u>copays</u> indicated above, according to drug status (generic/preferred/non-preferred) and retail or mail order.

*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 Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay/visit</u> plus 10% <u>coinsurance</u>	\$100 <u>copay/visit</u> plus 10% <u>coinsurance</u>	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	No Charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required; see your benefit booklet* for details.
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. Professional Services Covered at 10% <u>coinsurance</u> for In-Network and 30% <u>coinsurance</u> for Out-of-Network.
	Inpatient services	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required.

*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 Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	Preauthorization required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization required.
	Habilitation services	10% coinsurance	30% coinsurance	60 visits per calendar year for Physical Therapy and Occupational Therapy. 30 visits per calendar year for Speech Therapy.
	Skilled nursing care	No Charge	20% coinsurance	Preauthorization required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	20% coinsurance	Preauthorization 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 <u>plan</u> document for more information and a list of any other excluded services.)			
• Acupuncture	• Long-term care	• Routine foot care (with the exception of person with diagnosis of diabetes)	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Bariatric surgery	• Infertility treatment	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (with the exception of inpatient private duty nursing)
• Chiropractic care	• Most coverage provided outside the United States. See www.bcbsil.com		
• Hearing aids			

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, kwijijo 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	\$250
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	10%

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	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$250
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	10%

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	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$250
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	10%

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:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

*Note: Patient Pays Amount is capped at the individual out of pocket limit. Total Amounts may not add up due to rounding.

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>