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, call 1-800-458-6024 or at www.bcbsil.com. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For In-Network: $1,250 Individual/$3,750 Family For Out-of-Network: $2,500 Individual/$7,500 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain preventive care, services that charge a copay, prescription drugs, and emergency room services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For In-Network: $3,000 Individual/$6,000 Family For Out-of-Network: $6,000 Individual/$12,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balanced-billed charges, and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-458-6024 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30 copay/visit; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No Charge; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

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

### If you need drugs to treat your illness or condition
More information about prescription drug coverage is available at [www.bcbsil.com](http://www.bcbsil.com).

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic drugs</strong></td>
<td><strong>In-Network Provider</strong> <em>(You will pay the least)</em></td>
<td><strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em> <strong>34-day supply at Retail</strong> <strong>90-day supply at Mail Order</strong></td>
</tr>
<tr>
<td></td>
<td>$10 copay/prescription <em>(retail)</em></td>
<td>$10 copay/prescription <em>(retail)</em> deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$20 copay/prescription <em>(mail order)</em></td>
<td>$20 copay/prescription <em>(mail order)</em> deductible does not apply</td>
</tr>
<tr>
<td><strong>Preferred brand drugs</strong></td>
<td>$40 copay/prescription <em>(retail)</em></td>
<td>$40 copay/prescription <em>(retail)</em> deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$80 copay/prescription <em>(mail order)</em></td>
<td>$80 copay/prescription <em>(mail order)</em> deductible does not apply</td>
</tr>
<tr>
<td><strong>Non-preferred brand drugs</strong></td>
<td>$60 copay/prescription <em>(retail)</em></td>
<td>$60 copay/prescription <em>(retail)</em> deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$120 copay/prescription <em>(mail order)</em></td>
<td>$120 copay/prescription <em>(mail order)</em> deductible does not apply</td>
</tr>
<tr>
<td><strong>Specialty drugs</strong></td>
<td>$150 copay/prescription <em>(retail)</em></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>deductible does not apply</td>
<td>Coverage based on group policy. Prior authorization may be required.</td>
</tr>
<tr>
<td></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
</tbody>
</table>

### If you have outpatient surgery

| Facility fee (e.g., ambulatory surgery center) | 20% coinsurance; deductible does not apply | 40% coinsurance; deductible does not apply | Preauthorization may be required. |
| Physician/surgeon fees              | 20% coinsurance; deductible does not apply | 40% coinsurance; deductible does not apply | None                           |

### If you need immediate medical attention

| Emergency room care          | $75 copay/visit; deductible does not apply | $75 copay/visit; deductible does not apply | Copay waived if admitted. |
| Emergency medical transportation | 20% coinsurance | 20% coinsurance | Local ground or air transportation. Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details. |
| Urgent care                  | 20% coinsurance; deductible does not apply | 40% coinsurance; deductible does not apply | None |

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization may be required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
<td>60 visits per benefit period for Occupational Therapy, 60 visits per benefit period for Speech Therapy and 60 visits per benefit period for Physical Therapy. Preauthorization may be required.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization may be required.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance; deductible does not apply</td>
<td>40% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization may be required.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
<th></th>
<th>Services Covered (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Hearing aids</td>
<td>Routine eye care (Adult and Children)</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Long term care</td>
<td>Routine foot care (with the exception of person with diagnosis of diabetes)</td>
</tr>
<tr>
<td>Dental care (Adult and Children)</td>
<td>Non-emergency care when traveling outside the U.S.</td>
<td>Weight loss programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Infertility treatment</td>
<td>Private-duty nursing (with the exception of inpatient private duty nursing)</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Most coverage provided outside of the United States. See <a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
<td></td>
</tr>
</tbody>
</table>

**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 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

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.
- 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, kwijjigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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)

**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)

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

**Total Example Cost**

- Peg: $12,800
- Joe: $7,400
- Mia: $1,900

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,100</td>
<td>$1,100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Peg: $60
- Joe: $60
- Mia: $0

**The total cost Peg would pay is**

- Peg: $3,040
- Joe: $2,660
- Mia: $1,300

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don’t have a card, call 855-710-6984.

Arabic

Français

Deutsch

Ελληνικά

Gujarati

Hindi

Italiano

한국어

Diné

Polski

Русский

Español

Tagalog

Urdu

Tiếng Việt
Health care coverage is important for everyone.

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 or disability.

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

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, Illinois  60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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/portal/lobby.jsf