

 **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 1-800-458-6024. 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:
<b>What is the overall deductible?</b>	For <u>In-Network</u> provider: \$250 Individual /\$500 Family For <u>Out-of-Network</u> provider: \$500 Individual /\$1,500 Family <u>Copays</u> and per occurrence <u>deductibles</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 <u>individual 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> , <u>copays</u> , <u>prescription drugs</u> and emergency room services are 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. 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 preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$300 <u>deductible</u> for Out-of-Network hospital admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	For <u>In-Network</u> provider: \$1,250 Individual /\$3,750 Family For <u>Out-of-Network</u> provider: \$2,500 Individual /\$7,500 Family <u>Prescription drug expense limit</u> : \$5,900 Individual/ \$10,550 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>	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside of the <u>out-of-pocket</u> limits. The	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
	cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of <u>In-Network Providers</u> , visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> 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 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 <u>referral</u> to see a <u>specialist</u>?</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 Provider (You will pay the least)	Out-of-Network Provider (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	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Virtual Visits (Telehealth) covered at the <u>In-Network Provider</u> level per visit by a Designated Virtual Network Provider. No Virtual Coverage <u>out-of-network</u> .
	Specialist visit	\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	None
	Preventive care/screening/immunization	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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization 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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 1-800-711-0917	Generic drugs	\$15 <u>copay</u> retail / \$37.50 <u>copay</u> mail order	Not covered	RX Out-of-Pocket Expense Limit: \$5,900 Individual/\$10,550 Family Retail 34 day supply. Mail order 90 day supply. Prior authorization may be required. Please see "Important Questions" regarding the <u>plan's out-of-pocket limit</u> .
	Preferred brand drugs	\$30 <u>copay</u> retail / \$75 <u>copay</u> mail order	Not covered	
	Non-preferred brand drugs	\$50 <u>copay</u> retail / \$125 mail order	Not covered	
	Specialty drugs	\$50 copay	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization 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>	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply.	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply.	<u>Copay</u> waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization required. \$300 <u>deductible</u> per admission <u>Out-of-Network providers</u> .
<b>If you have a hospital stay</b>	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](http://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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$20 PCP <u>copay</u> applies to psychotherapy office visit only. <u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. \$300 <u>deductible</u> per admission Out-of-Network providers.
<b>If you are pregnant</b>	Office visits	\$20 <u>copay</u>	40% <u>coinsurance</u>	<u>Copay</u> applies to the 1st prenatal visit only. <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 professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$300 <u>deductible</u> per admission Out-of-Network providers.
	Childbirth/delivery facility services	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 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	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required. Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Preauthorization may be required. 100 visits maximum per benefit period for Occupational Therapy. 100 visits maximum per benefit period for Speech Therapy. 100 visits maximum per benefit period for Physical Therapy
	<u>Habilitation services</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required. Limited to 60 days per calendar year. \$300 <u>deductible</u> per admission Out-of-Network providers.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required. Benefits are limited to items used to serve a medical purpose. <u>DME</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>	Preauthorization may be required. \$300 <u>deductible</u> per admission Out-of-Network providers.
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.)

- Acupuncture
- 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.)

- 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](http://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](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 1-800-458-6024 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 1-800-458-6024.

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, kwijijigo 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)

<b>The plan's overall deductible</b>	\$250
<b>Specialist copayment</b>	\$40
<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*)

**Total Example Cost** **\$12,700**

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

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,000

#### What isn't covered

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,310</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>	\$250
<b>Specialist copayment</b>	\$40
<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*)

**Total Example Cost** **\$5,600**

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

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$100

#### What isn't covered

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,170</b>

### Mia's Simple Fracture

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

<b>The plan's overall deductible</b>	\$250
<b>Specialist copayment</b>	\$40
<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*)

**Total Example Cost** **\$2,800**

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

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$200

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$850</b>

\*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., 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>