




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 1-855-686-8517 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.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For <u>In-Network</u> : \$400 Individual/\$1,200 Family For <u>Out-of-Network</u> : \$800 Individual/\$2,400 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> , <u>prescription drugs</u> and emergency care 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>In-Network</u> : \$1,200 Individual/\$2,400 Family For <u>Out-of-Network</u> : \$4,500 Individual/\$9,000 Family <u>Affordable Care Act(ACA) Cost Share Maximum for In-Network services: \$2,500 individual/\$5,000 Family</u>	The <u>out-of-pocket limit</u> including the ACA Cost Share Maximum for In-Network Services 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balanced-billed</u> charges, copays, skeletal adjustments, expenses in excess of the lifetime of calendar year maximums, and healthcare 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> . Network medical copayments and prescription drug copayments will count towards the ACA Cost Share Maximum for In-Network Services.
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsil.com or call 1-855-686-8517 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. When a covered member uses the services of a <u>In-Network Independent Lab</u> provider there will be no out-of-pocket expense to the member and covered services will be covered at 100%.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

* 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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com.</p>	Generic drugs	\$12 <u>copay</u> /prescription (retail) – 30-day supply \$24 <u>copay</u> /prescription (retail) – 60-day supply \$36 <u>copay</u> /prescription (retail) – 90-day supply \$30 <u>copay</u> /prescription (mail order/90-day retail); <u>deductible</u> does not apply	\$12 <u>copay</u> /prescription (retail) – 30-day supply \$24 <u>copay</u> /prescription (retail) – 60-day supply \$36 <u>copay</u> /prescription (retail) – 90-day supply; <u>deductible</u> does not apply	30-day 60-day and 90-day retail/ 90-day mail One copay per 30 days supply up to 90-day supply 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.
	Preferred brand drugs	\$25 <u>copay</u> /prescription (retail) – 30-day supply \$50 <u>copay</u> /prescription (retail) – 60-day supply \$85 <u>copay</u> /prescription (retail) – 90-day supply \$55 <u>copay</u> /prescription (mail order/90-day retail); <u>deductible</u> does not apply	\$25 <u>copay</u> /prescription (retail) – 30-day supply \$50 <u>copay</u> /prescription (retail) – 60-day supply \$85 <u>copay</u> /prescription (retail) – 90-day supply; <u>deductible</u> does not apply	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Dispensing limit may apply to certain drugs.
	Non-preferred brand drugs	\$40 <u>copay</u> /prescription (retail) – 30-day supply \$80 <u>copay</u> /prescription (retail) – 60-day supply \$130 <u>copay</u> /prescription (retail) – 90-day supply \$100 <u>copay</u> /prescription (mail order/90-day retail); <u>deductible</u> does not apply	\$40 <u>copay</u> /prescription (retail) – 30-day supply \$80 <u>copay</u> /prescription (retail) – 60-day supply \$130 <u>copay</u> /prescription (retail) – 90-day supply; <u>deductible</u> does not apply	You have the option to fill the first two months of a newly prescribed maintenance medication at a network retail pharmacy. After the first two fills you are required to fill a 90-day supply at either a 90-day network pharmacy or through Home Delivery.
	<u>Specialty drugs</u>	Copay plus 3% of drug cost up to a maximum of \$150 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply	Copay plus 3% of drug cost up to a maximum of \$150 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply	Prior <u>authorization</u> may be required. Specialty retail limited to a 30-day supply. You are required to purchase self-administered specialty drugs through AllianceRx Walgreens Prime Specialty Pharmacy.

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 <u>copays</u> per person per calendar year. <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>	\$300 <u>copay/visit</u> plus 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$300 <u>copay/visit</u> plus 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	Emergency room <u>copay</u> waived 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>	Facility: \$40 <u>copay/visit</u> plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply Physician: 10% <u>coinsurance</u>	Facility: \$40 <u>copay/visit</u> plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply Physician: 10% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 <u>copays</u> per person per calendar year. <u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <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 mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	\$25 PCP <u>copay</u> applies to psychotherapy office visit only. <u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Inpatient services	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 <u>copays</u> per person per calendar year. <u>Preauthorization</u> required.
If you are pregnant	Office visits	\$25 <u>copay/visit</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Copay</u> applies to first prenatal visit (per pregnancy). <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 <u>copays</u> per person per calendar year. <u>Preauthorization</u> may be 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 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>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	20 visits per calendar year per therapy. <u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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>Preauthorization</u> may be required.
	<u>Hospice services</u>	\$250 <u>copay/admission</u> plus 10% <u>coinsurance</u>	\$550 <u>copay/admission</u> plus 30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	The <u>plan</u> only covers vision screening services required by federal law.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	The <u>plan</u> only covers dental screening services required by federal law.

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

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)
- Long term care
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (with the exception of person diagnosed with diabetes)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (for treatment of morbid obesity)
- Chiropractic care
- Hearing aids (Coverage for children up to age 18)
- Infertility treatment
- Private-duty nursing (with the exception of inpatient private duty nursing)

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 1-855-686-8517, 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 1-855-686-8517 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 1-855-686-8517.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-686-8517.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-686-8517.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-686-8517.

—————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)

■ <u>The plan's overall deductible</u>	\$400
■ <u>Primary care physician copayment</u>	\$25
■ <u>Hospital (facility) both</u>	\$250 + 10%
■ <u>Other coinsurance</u>	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$275
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,475

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$400
■ <u>Primary care physician copayment</u>	\$25
■ <u>Hospital (facility) both</u>	\$250 + 10%
■ <u>Other coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$140
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,240

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$400
■ <u>Primary care physician copayment</u>	\$25
■ <u>Emergency Room</u>	\$300 + 15%
■ <u>Other coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$325
<u>Coinsurance</u>	\$160
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$885

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

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>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>