**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 deductible?** | For In-Network:<br>$1,400 Individual/$2,800 Family<br>For Out-of-Network:<br>$2,800 Individual/$5,600 Family | 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, the family deductible must be satisfied before the plan will pay expenses for any covered family member, except preventive services and certain prescription drugs. |
| **Are there services covered before you meet your deductible?** | Yes. Certain preventive care, services that charge a copay and certain prescription drugs are covered before you meet your deductible. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For In-Network:<br>$4,050 Individual/$8,100 Family<br>For Out-of-Network:<br>$7,900 Individual/$15,800 Family | 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. |
| **What is not included in the out-of-pocket limit?** | Premiums, balanced-billed charges, skeletal adjustments, expenses in excess of the lifetime of calendar year maximums, and healthcare this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.bcbsil.com or call 1-855-686-8517 for a list of network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

*Revised 1/26/2022*

 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 | $25 copay/visit, then 20% | 40% coinsurance | None |
| | Specialist visit | $30 copay/visit, then 20% | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Preauthorization may be required; see your benefit booklet* for details. When a covered member uses the services of an In-Network Independent Lab provider there will be no out-of-pocket expense to the member and covered services will be covered at 100%, after the calendar year deductible is met, except for preventive services. |
| | Imaging (CT/PET scans, MRIs) | 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.bcbsil.com. | Generic drugs | $12 copay/prescription (retail) – 30-day supply<br>$24 copay/prescription (retail) – 60-day supply<br>$36 copay/prescription (retail) – 90-day supply<br>$30 copay/prescription (mail order/90-day retail) | $12 copay/prescription (retail) – 30-day supply<br>$24 copay/prescription (retail) – 60-day supply<br>$36 copay/prescription (retail) – 90-day supply | For covered drugs classified under IRS guidelines as preventive drugs you will pay the Copayments shown in this table, before you satisfy the calendar year deductible.<br><br>30-day 60-day and 90-day retail/ 90-day mail<br><br>One copay per 30 days supply up to 90-day supply<br><br>Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.<br><br>Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.<br><br>Dispensing limit may apply to certain drugs.<br><br>Physician administered drugs are paid under medical.<br><br>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 retail pharmacy or through Home Delivery. |
| | Preferred brand drugs | $25 copay/prescription (retail) – 30-day supply<br>$50 copay/prescription (retail) – 60-day supply<br>$85 copay/prescription (retail) – 90-day supply<br>$55 copay/prescription (mail order/90-day retail) | $25 copay/prescription (retail) – 30-day supply<br>$50 copay/prescription (retail) – 60-day supply<br>$85 copay/prescription (retail) – 90-day supply | |
| | Non-preferred brand drugs | $40 copay/prescription (retail) – 30-day supply<br>$80 copay/prescription (retail) – 60-day supply<br>$130 copay/prescription (retail) – 90-day supply<br>$100 copay/prescription (mail order/90-day retail) | $40 copay/prescription (retail) – 30-day supply<br>$80 copay/prescription (retail) – 60-day supply<br>$130 copay/prescription (retail) – 90-day supply | |
| | Specialty drugs | Copay plus 3% of drug cost up to a maximum of $150 copay/prescription (retail) | Not Covered | Prior authorization may be required.<br>Specialty retail limited to a 30-day supply.<br>You are required to purchase self-administered specialty drugs through Accredo Specialty Pharmacy (as of 10/1/2021). |

| 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 copay/admission plus 20% coinsurance | $550 copay/admission plus 40% coinsurance | In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 copays per person per calendar year. Preauthorization may be required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit plus 20% coinsurance | $300 copay/visit plus 20% coinsurance | Emergency room copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details. |
| | Urgent care | Facility: $40 copay/visit plus 20% coinsurance | Facility: $40 copay/visit plus 20% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 copay/admission plus 20% coinsurance | $550 copay/admission plus 40% coinsurance | In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 copays per person per calendar year. Preauthorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 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 | $25 copay/office visit;<br><br>20% coinsurance for other outpatient services | 40% coinsurance | PCP copay applies to psychotherapy office visit only. Preauthorization may be required; see your benefit booklet* for details. |
| | Inpatient services | $250 copay/admission plus 20% coinsurance | $550 copay/admission plus 40% coinsurance | In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 copays per person per calendar year. Preauthorization required. |
| **If you are pregnant** | Office visits | $25 copay/visit | 40% coinsurance | Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, 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 | |
| | Childbirth/delivery facility services | $250 copay/admission plus 20% coinsurance | $550 copay/admission plus 40% coinsurance | In-Patient Hospital admission and Outpatient Surgical copay has a combined max of 3 copays per person per calendar year. Preauthorization 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** | Home health care | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 20 visits per calendar year per therapy. Preauthorization may be required. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | $250 copay/admission plus 20% coinsurance | $550 copay/admission plus 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 | $250 copay/admission plus 20% coinsurance | $550 copay/admission plus 40% coinsurance | Preauthorization may be required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | The plan 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 plan only covers dental screening services required by federal law. |

## 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
- 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 1-855-686-8517or 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, kwiijigo 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)

| | |
|---|---|
| The plan's overall deductible | $1,400 |
| Primary care physician copayment | $25 |
| Hospital (facility) both | $250 + 20% |
| Other coinsurance | 20% |

**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** | **$12,687** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $285 |
| Coinsurance | $2,178 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,923** |

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

| | |
|---|---|
| The plan's overall deductible | $1,400 |
| Primary care physician copayment | $25 |
| Hospital (facility) both | $250 + 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** | **$5,601** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $430 |
| Coinsurance | $158 |
| *What isn't covered* | |
| Limits or exclusions | $22 |
| **The total Joe would pay is** | **$2,010** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,400 |
| Primary care physician copayment | $25 |
| Emergency Room | $300 + 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $65 |
| Coinsurance | $211 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,676** |

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 | Phone: 855-664-7270 (voicemail) |
| 300 E. Randolph St. | TTY/TDD: 855-661-6965 |
| 35th Floor | Fax: 855-661-6960 |
| Chicago, Illinois 60601 | 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 | Phone: 800-368-1019 |
| 200 Independence Avenue SW | TTY/TDD: 800-537-7697 |
| Room 509F, HHH Building 1019 | Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf |
| Washington, DC 20201 | Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html |