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: $2,150 Individual/$4,300 Family For Out-of-Network: $4,300 Individual/$8,600 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.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is 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: $5,550 Individual/$11,100 Family For Out-of-Network: $11,100 Individual/$22,200 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 limit 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, 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.

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% coinsurance	45% coinsurance	None
	Specialist visit	25% coinsurance	45% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	45% 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)	25% coinsurance	45% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% 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	25% coinsurance	45% coinsurance	30-day retail/ 90-day mail Certain preventive medications will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Non-Participating drug provider, you are responsible for 30% of the eligible amount after the copayment or coinsurance. Dispensing limit may apply to certain drugs. Physician administered drugs are paid under medical. You have the option to fill the first two months of a newly prescribed **Brand Name** maintenance medication at a network retail pharmacy. After the first two fills you are **required** to fill a 90-day supply through Home Delivery.
	Preferred brand drugs	25% coinsurance	45% coinsurance	
	Non-preferred brand drugs	25% coinsurance	45% coinsurance	
	Specialty drugs	3% of drug cost up to a $400 maximum	Not Covered	Prior authorization may be required. You are required to purchase self-administered specialty drugs through Accredo 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)	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	25% coinsurance	25% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	25% coinsurance	45% coinsurance	Preauthorization required.
If you are pregnant	Office visits	25% coinsurance	45% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	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	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Rehabilitation services	25% coinsurance	45% coinsurance	20 visits per benefit period per therapy; then medical review required. Preauthorization may be required.
	Habilitation services	25% coinsurance	45% coinsurance	
	Skilled nursing care	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Durable medical equipment	25% coinsurance	45% 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	25% coinsurance	45% coinsurance	Includes pediatric palliative care. 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 program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery • 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	$2,150
Primary care physician coinsur.	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,150
Copayments	$0
Coinsurance	$2,607
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,817**

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

The plan's overall deductible	$2,150
Primary care physician coinsur.	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,150
Copayments	$0
Coinsurance	$818
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$2,990**

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

The plan's overall deductible	$2,150
Primary care physician coinsur.	25%
Emergency Room	25%
Other coinsurance	25%

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	$2,150
Copayments	$0
Coinsurance	$163
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,313**

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