



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 1-800-892-2803 or at <https://policy-srv.box.com/s/qx76htdfahy9h4og8ooh5a6tzvec4mvg>.

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 www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$250 Individual / \$500 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> .
<u>Are there services covered before you meet your <u>deductible</u>?</u>	Yes. Certain preventive care is 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 <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	\$2,000 Individual / \$4,000 Family Prescription drug expense limit: \$3,000 Individual / \$9,000 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.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges, and health care 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> .
<u>Will you pay less if you use a <u>network provider</u>?</u>	Yes. See www.bcbsil.com or call 1-800-892-2803 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 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 provider before you get services.
<u>Do you need a <u>referral</u> to see a <u>specialist</u>?</u>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 provider's office or clinic	Primary care visit to treat an injury or illness	\$35/visit; <u>deductible</u> does not apply	Not Covered	Services or supplies that are not ordered by your <u>Primary Care Physician</u> or individual <u>Principal Health Care Provider</u> , except emergency and routine vision exams, are not covered.
	<u>Specialist</u> visit	\$60/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	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 plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	No Charge; <u>deductible</u> does not apply	Not Covered	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called BCBSIL)
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*For more information about limitations and exceptions, see the plan or policy document at
<https://policy-srv.box.com/s/qx76htdfahy9h4og8oooh5a6tzvec4mvg>.

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/rx-drugs/drug-lists/drug-lists	Generic drugs	\$10/prescription (retail) \$20/prescription (mail order); <u>deductible</u> does not apply	Not Covered	34-day supply at Retail 90-day supply at Mail Order Rx Out-of-Pocket Expense Limit: \$3,000 Individual / \$9,000 Family
	Preferred brand drugs	\$40/prescription (retail) \$80/prescription (mail order); <u>deductible</u> does not apply	Not Covered	Dispensing limit may apply to certain drugs. Certain individual <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.
	Non-preferred brand drugs	\$60/prescription (retail) \$120/prescription (mail order); <u>deductible</u> does not apply	Not Covered	The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35, when obtained from a Participating Pharmacy.
	<u>Specialty drugs</u>	\$60/prescription; <u>deductible</u> does not apply	Not Covered	Prior authorization may be required. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	<u>Referral</u> required.
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$250/visit; <u>deductible</u> does not apply ER Physician Charges: No Charge; <u>deductible</u> does not apply	Facility Charges: \$250/visit; <u>deductible</u> does not apply ER Physician Charges: No Charge; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Ground transportation only.
	<u>Urgent Care</u>	\$35/visit; <u>deductible</u> does not apply	Not Covered	Must be affiliated with member's chosen medical group or <u>referral</u> required.

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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 a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<u>Referral</u> required.
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit; <u>deductible</u> does not apply	Not Covered	Unlimited visits. <u>Referral</u> not required for office visits.
	Inpatient services	No Charge	Not Covered	Unlimited days. <u>Referral</u> required.
If you are pregnant	Office visits	\$35 PCP/\$60 SPC/visit; deductible does not apply	Not Covered	<u>Copayment</u> applies for the 1st prenatal visit only. <u>Cost sharing</u> does not apply for <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge; <u>deductible</u> does not apply	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	<u>Referral</u> required.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Rehabilitation services</u>	No Charge; deductible does not apply	Not Covered	
	<u>Habilitation services</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Skilled nursing care</u>	No Charge; deductible does not apply	Not Covered	Excludes custodial care. <u>Referral</u> required.
	<u>Durable medical equipment</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required. Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.

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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 your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	Limited to one exam every 12 months at participating providers.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (only when medically necessary)
- Chiropractic care
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (1 per ear every 24 months)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Most coverage provided outside the United States. See www.bcbst.com
- Routine eye care
- Routine foot care (only in connection with diabetes)

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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: For group health coverage contact the plan Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com. For group health coverage subject to ERISA contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 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 1-877-527-9431 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 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo holne' 1-800-892-2803.

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>	\$250
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other</u>	\$0

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>	\$50
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$360

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>	\$250
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other</u>	\$0

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>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other</u>	\$0

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>	\$40
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$440

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



Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language 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, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html
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This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
Arabic العربية	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.



中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારું માટે ઉપલબ્ધ છે. યોગ્ય ઓફિશિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिन्दी Hindi	ધ્યાન દેં: યदि આપ હિન્દી બોલતે હોય, તો આપને લિએ નિઃશુલ્ક ભાષા સહાયતા સેવાએ ઉપલબ્ધ હોતી હોય. સુલભ પ્રારૂપો મેં જાનકારી પ્રદાન કરને કે લિએ ઉપયુક્ત સહાયક સાધન ઔર સેવાએ ભી નિઃશુલ્ક ઉપલબ્ધ હોય. 855-710-6984 (TTY: 711) પર કોલ કરો યા અપને પ્રદાતા સે બાત કરો.
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáñiłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohíjí' 855-710-6984 (TTY: 711) hodíilnih doodago niká'análwo'í bich'í' hanidzíih.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قبل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تلنام: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه دین: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کننڈہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.