




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/ws2nodcp0f9dhbeznmy2hxayk6bu7okr>.

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: |
|---|---|--|
| What is the overall deductible? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | No. | You will have to meet the deductible before the plan pays for any services. |
| 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? | \$1,500 Individual / \$3,000 Family Prescription drug expense limit: \$5,100 Individual / \$10,200 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 limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care 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 1-800-892-2803 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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

 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 | \$20/visit | Not Covered | Services or supplies that are not ordered by your <u>Primary Care Physician</u> or Women's Principal Health Care <u>Provider</u> , except emergency and routine vision exams, are not covered. |
| | <u>Specialist</u> visit | \$40/visit | Not Covered | <u>Referral</u> required. |
| | <u>Preventive care/screening/immunization</u> | No Charge | 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 <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | Not Covered | <u>Referral</u> required. |
| | Imaging (CT/PET scans, MRIs) | No Charge | 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/ws2nodcp0f9dhbeznm2hxayk6bu7okr>.

| 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) | Not Covered | 34-day supply at Retail 90-day supply at Mail Order |
| | Preferred brand drugs | \$20/prescription (retail) \$40/prescription (mail order) | Not Covered | Rx Out-of-Pocket Expense Limit: \$5,100 Individual / \$10,200 Family |
| | Non-preferred brand drugs | \$35/prescription (retail) \$70/prescription (mail order) | Not Covered | Dispensing limit may apply to certain drugs. 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. |
| | <u>Specialty drugs</u> | \$75/prescription (retail) | Not Covered | The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained from a Participating Pharmacy. <u>Specialty drug</u> coverage based on group policy. 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: \$100/visit ER Physician Charges: No Charge | Facility Charges: \$100/visit ER Physician Charges: No Charge | <u>Copayment</u> waived if admitted. |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | Ground transportation only. |
| | <u>Urgent Care</u> | \$20/visit | 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 | \$20/visit | Not Covered | Unlimited visits. <u>Referral</u> required. |
| | Inpatient services | No Charge | Not Covered | Unlimited days. <u>Referral</u> required. |
| If you are pregnant | Office visits | \$20 PCP/\$40 SPC/visit | Not Covered | <u>Copayment</u> applies for 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> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No Charge | 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 | Not Covered | <u>Referral</u> required. |
| | <u>Rehabilitation services</u> | No Charge | Not Covered | 60 visits combined for all therapies. <u>Referral</u> required. |
| | <u>Habilitation services</u> | No Charge | Not Covered | |
| | <u>Skilled nursing care</u> | No Charge | Not Covered | Excludes custodial care. <u>Referral</u> required. |
| | <u>Durable medical equipment</u> | No Charge | 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 | 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 | Not Covered | Limited to one exam every 12 months at participating <u>providers</u> . |
| | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | | |
|--|--|---|--|
| <ul style="list-style-type: none"> • Custodial care • Dental care (Adult) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Weight loss programs (except when medically supervised) | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | | |
|---|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) • Hearing aids (for children 1 per ear every 24 months, for adults up to \$2,500 per ear every 24 months) • Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period) | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsil.com • Routine eye care (Adult) • 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 at'ohwol ninisingo, kwijigo 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)

| | |
|---|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ Hospital (facility) <u>copayment</u> | \$0 |
| ■ Other <u>copayment</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:

| <i>Cost sharing</i> | |
|-----------------------------------|-------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$30 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$90 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ Hospital (facility) <u>copayment</u> | \$0 |
| ■ Other <u>copayment</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:

| <i>Cost sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$600 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$620 |

Mia's Simple Fracture

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

| | |
|---|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ Hospital (facility) <u>copayment</u> | \$0 |
| ■ Other <u>copayment</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:

| <i>Cost sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$200 |

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



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

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., 35th 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>

| To receive language or communication assistance free of charge, please call us at 855-710-6984. | |
|---|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jì' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |

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