



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 1-888-979-4516 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 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>	In-Network: \$750 Individual/\$1,500 Family Out-of-Network: \$1,500 Individual/\$3,000 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 deductible?</u>	Yes. Certain <u>preventive care</u> , services that charge <u>copay</u> , <u>prescription drugs</u> and emergency room 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 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>	In-Network: \$3,000 Individual/\$6,000 Family Out-of-Network: \$6,000 Individual/\$12,000 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>	<u>Premiums</u> , <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 network provider?</u>	Yes. See www.bcbsil.com or call 1-888-979-4516 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 (balance billing). 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.
<u>Do you need a referral to see a 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits: \$25/visit; <u>deductible</u> does not apply. See your benefit booklet* for details.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	40% <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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com/bmofinancialgroup or by calling member services at 1-877-795-2926.	Generic drugs	\$10 copay/prescription-retail \$25 copay/prescription-mail (31-90)	Same as in-network, retail pricing applies. Mail order not covered.	Smart90 requires you to fill maintenance medications at a Smart90 retailer (Walgreens or CVS), or through ESI home delivery. You can get two retail 30 day grace fills for maintenance medications. Subject to deductible (some exclusions apply). Infertility medications lifetime limit of \$40,000. The Dispense as Written (DAW1&2) program requires you to use a generic equivalent drug when available. If you choose to purchase a brand drug when a generic equivalent is available, you pay the generic copayment plus the difference in cost between the brand and the generic. Extra cost will not apply toward deductible or out-of-pocket maximum. Required to be filled through Express Script's specialty mail order pharmacy, Accredo Health Group, Inc.
	Preferred brand drugs	30% coinsurance/prescription min \$25, max \$100-retail 30% coinsurance/prescription min \$62.50, max \$250-mail (31-90 day)	Same as in-network, retail pricing applies. Mail order not covered.	
	Non-preferred brand drugs	40% coinsurance/prescription min \$50-retail 40% coinsurance/prescription min \$125-mail (31-90 day)	Same as in-network, retail pricing applies. Mail order not covered.	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.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)	
				RX Deductible: \$250 Individual/\$500 Family.
	<u>Specialty drugs</u>	Based on category (generic, Formulary, Nonformulary)	Not covered.	Required to be filled through Express Script's specialty mail order pharmacy Accredo health Group, Inc.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$300 <u>copay/visit</u> ; <u>deductible</u> does not apply ER Physician Charges: 20% <u>coinsurance</u>	Facility Charges: \$300 <u>copay/visit</u> ; <u>deductible</u> does not apply ER Physician Charges: 20% <u>coinsurance</u>	<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. Ground and air transportation covered.
	<u>Urgent care</u>	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. Out-of-Network: \$400 non-notification penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay/visit</u> ; <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	Virtual Visits: \$25/visit; <u>deductible</u> does not apply. See your benefit booklet* for details. <u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. Out-of-Network: \$400 non-notification penalty.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.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 are pregnant	Office visits	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Copay 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Out-of-Network: \$400 non-notification penalty.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required. Limited to 120 visits per benefit period.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Preauthorization may be required. Limited to 60 visits combined per benefit period for occupational therapy, speech therapy and physical therapy.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per benefit period. Preauthorization required. Out-of-Network: \$400 non-notification penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be 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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization required. Out-of-Network: \$400 non-notification penalty.
If your child needs dental or eye care	Children's eye exam	\$25 PCP/\$40 SPC <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Visual Acuity Screening only, no charge if preventive.
	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.)
<ul style="list-style-type: none">• Dental care (Adult)• Long-term care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) <ul style="list-style-type: none">• Acupuncture (20 visits per calendar year)• Bariatric surgery• Chiropractic care (Chiropractic and Osteopathic manipulation limited to 20 visits per calendar year)• Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)• Routine foot care with the exception of person with diagnosis of diabetes)• Weight loss programs

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 1-888-979-4516, 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 1-888-979-4516 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

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 1-888-979-4516.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-979-4516.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-979-4516.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-979-4516.

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>	\$750
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$2,200

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,040

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>	\$750
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$30

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,600

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$200

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,550



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	للتلقي 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 855-710-6984 પર કોલ કરો.
हिन्दी	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 855-710-6984 번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit'sá'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 ji' 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 لئے، براو کرم بیٹن 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.