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, visit www.bcbsil.com or by calling 1-800-458-6024. 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.health care.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Blue Choice Option: $500 Individual/$1,500 Family In-Network: $625 Individual/$1,875 Family Out-of-Network: $3,000 Individual/$9,000 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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and services that a copay 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $600 for Out-of-Network hospital admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Blue Choice Option: $1,500 Individual/$4,500 Family In-Network: $2,125 Individual/$6,375 Family Out-of-Network: $9,000 Individual/$27,000 Family Prescription drug limit: $5,525 Individual/$9,245 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 1-800-458-6024 for a list of Network Providers.	You pay the least if you use a provider in Blue Choice Option. You pay more if you use a provider in 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

Important Questions	Answers	Why This Matters:
		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
		Blue Choice Option (You will pay the least)	In-Network Providers (You will pay more)	Out-of-Network Providers (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 copay/visit; deductible not apply	$25 copay/visit; deductible not apply	50% coinsurance	Virtual visits: $20/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$40 copay/visit; deductible not apply	$50 copay/visit; deductible not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	Certain women's preventive services will be covered with no cost to the member. For a full list of these services, please contact BCBS Customer Service. 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)	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Coinsurance may vary if services rendered in a professional setting.
	Imaging (CT/PET scans, MRIs)	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	50% 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
		Blue Choice Option (You will pay the least)	In-Network Providers (You will pay more)	Out-of-Network Providers (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	$10 copay/retail $20 copay mail order	$10 copay/retail $20 copay mail order	Not Covered	Rx Out-of-Pocket Expense Limit: $5,525 Individual / $9,245 Family Retail 30 day supply Mail order 90 day supply Prior authorization may be required. Please see "Important Questions" regarding the plan's Out-of-Pocket limit.
	Preferred brand drugs	$25 copay/retail $50 copay mail order	$25 copay/retail $50 copay mail order	Not Covered	
	Non-preferred brand drugs	$75 copay/retail $150 copay mail order	$75 copay/retail $150 copay mail order	Not Covered	
	Specialty drugs	$75 copay/retail	$75 copay/retail	Not Covered	Covered at the applicable copays indicated above, according to dug status (generic/preferred/non-preferred).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	50% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit plus 10% coinsurance	$250 copay/visit plus 10% coinsurance	$250 copay/visit plus 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	10% coinsurance	30% coinsurance	50% 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
		Blue Choice Option (You will pay the least)	In-Network Providers (You will pay more)	Out-of-Network Providers (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required; see your benefit booklet* for details. $600 deductible per admission Out-of-Network providers.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ office visit; deductible not apply 10% coinsurance for other outpatient services	$25 copay/ office visit; deductible not apply 30% coinsurance for other outpatient services	50% coinsurance	PCP copay applies to psychotherapy office visit only. Preauthorization may be required; see your benefit booklet* for details. Virtual visits: $20/visit; deductible does not apply.
	Inpatient services	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required. $600 deductible per admission Out-of-Network providers.
If you are pregnant	Office visits	$20 copay/visit; deductible not apply	$25 copay/visit; deductible not apply	50% coinsurance	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	10% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required. $600 deductible per admission Out-of-Network providers.

*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
		Blue Choice Option (You will pay the least)	In-Network Providers (You will pay more)	Out-of-Network Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required.
	Rehabilitation services	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Habilitation services	10% coinsurance	30% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required. $600 deductible per admission Out-of-Network providers.
	Durable medical equipment	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required. $600 deductible per admission Out-of-Network providers.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Children)
- Long-term care
- Routine eye care (Adult and Children)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (1 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- 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 1-800-458-6024, 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 on how 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 1-800-458-6024 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 1-800-458-6024.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-6024.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-458-6024.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-458-6024.

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	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	
Deductibles	$500
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	
Deductibles	$500
Copayments	$700
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,250**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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 مجانًا، 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.
[illegible]	[illegible] 855-710-6984 [illegible]
[illegible]	[illegible] 855-710-6984 [illegible]
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
□□□	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee nlhaz'1. 1-866-560-4042 j8' hod7lni.
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، براہِ 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.