



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 1-800-828-3116 or at <https://policy-srv.box.com/s/n1rw6plguixbj4q0st5mskdcfjmj8eto>.

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:
<p>What is the overall deductible?</p>	<p>\$500 Individual/\$1,000 Family</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible amount</u> 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>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Certain <u>preventive care</u> and emergency room services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible amount</u>. 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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For <u>In-Network</u>: \$1,400 Individual/\$2,800 Family For <u>Out-of-Network</u>: \$3,000 Individual/\$6,000 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billing charges</u>, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.bcbsil.com or call 1-800-828-3116 for a list of <u>network providers</u>.</p>	<p>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 <u>provider</u> before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

! 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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Specialist visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	40% <u>coinsurance</u>	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	20% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	
	Generic drugs Preferred brand drugs	20% <u>coinsurance</u> 20% <u>coinsurance</u>	20% <u>coinsurance</u> 20% <u>coinsurance</u>	30-day supply at Retail 90-day supply at Mail Order
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com	Non-preferred brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>Out-of-Network drug providers</u> , you are responsible for 25% of the eligible amount after the <u>coinsurance</u> . 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. The amount you may pay per 30-day supply of covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained from a Preferred Participating or Participating Pharmacy.
		20% <u>coinsurance</u>	20% <u>coinsurance</u>	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/n1rw6plgulxbj4q0st5mskdcfjmj8eto>.

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)	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	<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.
	<u>Urgent Care</u>	No Charge	20% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a, <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Maternity care</u> may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/n1rw6plgulxbj4q0st5mskdcefmj8eto>.

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	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 15 visits per benefit period for occupational therapy, 10 visits per benefit period for speech therapy, and 45 visits per benefit period for physical therapy. <u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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>Preauthorization</u> may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

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	\$16 copay/visit; deductible does not apply	Not Covered	Limited to one exam visit per benefit period.
	Children's glasses	No Charge; deductible does not apply	Not Covered	Frames \$14, Single Vision Lenses \$14, Bifocal Lenses \$25, Trifocal Lenses \$35, Contact Lenses \$70, Lenticular Lenses \$70
	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 (only available for accidental care)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Long-term care
- 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
- Chiropractic care
- 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (Unlimited visits per calendar year)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/n1rw6plgulxbj4q0st5mskdcefmj8eto>.

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 1-800-828-3116, 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.ccio.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 1-800-828-3116 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 1-800-828-3116.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-828-3116.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-828-3116.

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 coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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

In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,460

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 coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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

In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

- **The plan's overall deductible** \$500
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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

In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900



BlueCross BlueShield of Illinois

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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	ان كان لديك أو لدى شخص تساعد أسئلة، فذلك الحق في الحصول على المساعدة والمعلومات الضرورية بتملك من دون أية تكلفة. للتحديث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، أو كنت لا تملك بطاقة، فتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διαρτηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. ફલ્પિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में नि:शुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객센터 서비스 번호로 전화하십시오. 회원이 아니거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
Diné Navajo	T'áá ní, éí doodagoo ta' da biká aana'íilwo'ígíí, na' ídítikíidgo, ts'ídá bee ná ahoóti'í' t'áá nílk' é níká a' doolwoi. Ata' haine'í' bich'í' haa'deesdzih' nímizingo, éí kwe' é da' íniishgi áká aana'íilwo'ígíí bich'í' hodíílnih, bee néehózmíí bine'í'qéé' bikáá'. Kojí atah naalísoos ná hadít' ééégoó éí doodagoo bee néehózmíngíí ádingo kojí' hodíílnih 855-710-6984.
Polski Polish	Jesli Ty lub osoba, ktorej pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezplatnej informacji i pomocy we własnym języku. Aby porozmawiac z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jezeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کرتے ہیں، کوئی سوال درپیش آئے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số 855-710-6984. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

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
300 E. Randolph St.
35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hscs.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
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/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>