**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 1-844-460-2803 or visit 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 https://www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Preferred provider: $1,500/individual or $3,000/family.<br>Nonpreferred provider: $2,500/individual or $5,000/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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Certain preventive care, services that charge a copay, prescription drugs, emergency room services, and services listed below as "No charge" 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 https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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?** | Preferred provider: $5,000/individual or $10,000/family.<br>Nonpreferred provider: $10,000/individual or $19,600/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 1-844-460-2803 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?** | 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 |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred 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 copay/visit (deductible does not apply) | 40% coinsurance after deductible | Virtual visit - preferred provider: $25 copay/visit for MDLive until the out-of-pocket limit is reached. After the out-of-pocket limit is reached, the $25 copay no longer applies for MDLive. No virtual visits coverage for a nonpreferred provider. |
| | Specialist visit | $40 copay/visit (deductible does not apply) | 40% coinsurance after deductible | None. |
| | Preventive care/screening/ immunization | No charge (deductible does not apply) | 40% coinsurance after deductible | 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) | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred 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.primetherapeutics.com. | Generic drugs | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | For maintenance medication under 90-Day My Way: 90-day supply at Retail or Mail Order.<br>30-day supply at Retail.<br>90-day supply at Mail Order.<br>Generic:<br>Retail: Minimum $10 up to maximum $40<br>Mail Order: Minimum $25 up to maximum $100.<br>Coinsurance does not apply to preventive drugs required by the Affordable Care Act.<br>Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.<br>For nonpreferred provider drugs, you are responsible for 25% of the eligible amount after the coinsurance. |
| | Preferred brand drugs | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | Preferred Brand:<br>Retail: Minimum $40 up to maximum $75<br>Mail: Minimum $100 up to Maximum $185 |
| | Non-preferred brand drugs | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | Retail and Mail Order: 20% coinsurance/ prescription (deductible does not apply) | Non-Preferred Brand:<br>Retail: Minimum $50 up to maximum $125<br>Mail: Minimum $140 up to Maximum $315 |
| | Specialty drugs | $150 copay/prescription (deductible does not apply) | Not covered | Specialty Drug coverage based on group policy. Preauthorization may be required. Specialty retail limited to a 30-day supply. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |
| **If you need immediate medical attention** | Emergency room care | Emergency Room: $500 copay plus Emergency Room Services: 20% coinsurance (deductible does not apply) | Preferred provider benefit applies. | Copay waived if admitted. Nonpreferred provider, non-emergency visit: $500 copay plus 40% coinsurance (deductible does not apply). Non-emergency use of the emergency room is subject to a $500 penalty and does not apply to the deductible or out-of-pocket limit. |
| | Emergency medical transportation | 20% coinsurance after deductible | Preferred provider benefit applies. | None. |
| | Urgent care | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit (deductible does not apply) and 20% coinsurance for other outpatient services | 40% coinsurance after deductible | Preauthorization is required for partial hospitalization and intensive outpatient services. Virtual visit - preferred provider: $25 copay/visit for MDLive until the out-of-pocket limit is reached. After the out-of-pocket limit is reached, the $25 copay no longer applies for MDLive. No virtual visits coverage for a nonpreferred provider. |
| | Inpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| **If you are pregnant** | Office visits | $25 PCP / $40 SPC copay/visit (deductible does not apply) | 40% coinsurance after deductible | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 40% coinsurance after deductible | 120 visits per benefit period combined with private duty nursing. Preauthorization is required. |
| | Rehabilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible | 90 visits combined per benefit period for physical, occupational, pulmonary, cognitive and speech therapies. |
| | Habilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Skilled nursing care | 20% coinsurance after deductible | 40% coinsurance after deductible | 90 day per benefit period. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to items used to serve a medical purpose. Benefits are provided for both purchase and rental (up to the purchase price). Preauthorization is required for all rentals and any purchase over $1,500. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| | Hospice services | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered. |
| | 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.)**

- Dental care (Adult and Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Children)
- Weight loss programs

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

- Acupuncture (limit 20/visits per calendar year)
- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limit 20/visits per calendar year)
- Cosmetic surgery (to correct congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases)
- Hearing aids (limit 1 new aid per ear, per 36-month period, up to $5,000 maximum)
- Infertility treatment (only to diagnose infertility)
- Private-duty nursing (outpatient only)
- Routine foot care (covered only with connection with diagnosis of diabetes)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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 1-844-460-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-460-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-460-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-460-2803.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*



* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

## 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** | **$1,500** |
| **Specialist copayment** | **$40** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $30 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,790** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$40** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $300 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,920** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$40** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,100** |

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