



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 : \$2,500/individual or \$5,000/family, per benefit period. Out of Network provider : \$5,000/individual or \$10,000/family, per benefit period.	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 , is 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, per benefit period. Out of Network provider : \$10,000/individual or \$19,600/family, per benefit period.	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). (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)	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% coinsurance after deductible	50% coinsurance after deductible	Telemedicine services via Virtual Primary Care/Teladoc P360: \$10 copayment . Deductible does not apply.
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	None.
	Preventive care/screening/immunization	No charge (deductible does not apply)	50% 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	50% coinsurance after deductible	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% 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)	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.primetherapeutics.com .	Generic drugs	Retail and Mail Order: 20% coinsurance / prescription after deductible)	Retail: 20% coinsurance / prescription after deductible) Mail Order: Not Covered	For maintenance medication under 90-Day My Way: 90-day supply at Retail or Mail Order. 30-day supply at Retail. 90-day supply at Mail Order.
	Preferred brand drugs	Retail and Mail Order: 20% coinsurance / prescription after deductible)	Retail: 20% coinsurance / prescription after deductible) Mail Order: Not Covered	Deductible and coinsurance do not apply to preventive drugs required by the Affordable Care Act.
	Non-preferred brand drugs	Retail and Mail Order: 20% coinsurance / prescription after deductible)	Retail: 20% coinsurance / prescription after deductible) Mail Order: Not Covered	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out of Network provider drugs, you are responsible for 25% of the eligible amount after the coinsurance
	Specialty drugs	Retail: 20% coinsurance / prescription after deductible)	Not covered	Specialty Drug coverage based on group policy. Preauthorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	50% 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)	Out of Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance deductible after	Preferred provider benefit applies.	Out of Network Provider : Non-emergency visit: \$500 copay plus 50% coinsurance deductible (does 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 deductible after	Preferred provider benefit applies.	None.
	Urgent care	20% coinsurance deductible after	50% coinsurance deductible after	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance deductible after	50% coinsurance deductible after	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance deductible after	50% coinsurance deductible after	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance deductible after	50% coinsurance deductible after	Preauthorization is required for Partial and Intensive Outpatient services. Virtual visit – 20% coinsurance deductible . No virtual visit coverage for out-of-network .
	Inpatient services	20% coinsurance deductible after	50% coinsurance deductible after	Preauthorization is required
If you are pregnant	Office visits	20% coinsurance deductible after	50% coinsurance deductible after	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 deductible after	50% coinsurance deductible after	
	Childbirth/delivery facility services	20% coinsurance deductible after	50% coinsurance deductible after	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred 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	Home health care	20% coinsurance deductible after	50% coinsurance deductible after	120 visits per benefit period combined with private duty nursing. Preauthorization is required.
	Rehabilitation services	20% coinsurance deductible after	50% coinsurance deductible after	90 visits combined per benefit period for physical, occupational, pulmonary, cognitive and speech therapies.
	Habilitation services	20% coinsurance deductible after	50% coinsurance deductible after	
	Skilled nursing care	20% coinsurance deductible after	50% coinsurance deductible after	90 days per benefit period. Preauthorization is required.
	Durable medical equipment	20% coinsurance deductible after	50% coinsurance deductible after	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.
	Hospice services	20% coinsurance deductible after	50% coinsurance deductible after	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.)

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|--|---|---|
| • Acupuncture (limit 20/visits per benefit period) | • Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases) | • Infertility treatment (only to diagnose infertility) |
| • Bariatric surgery | • Hearing aids (limit 1 new aid per ear per 36-month period, up to \$5,000 maximum) | • Private-duty nursing (outpatient only) |
| • Chiropractic care (Chiropractic and Osteopathic manipulation limit 20/visits per benefit period) | | • 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.

Traditional 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, kwijigo holne' 1-844-460-2803.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-844-460-2803 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-460-2803.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-460-2803.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-460-2803.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-844-460-2803.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$2,500
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,560

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.