



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 1-800-346-7072 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:
What is the overall deductible?	For Blue Choice Options: \$1,000 Individual / \$2,000 Family For In-Network: \$2,000 Individual / \$4,000 Family For Out-of-Network: \$4,000 Individual / \$8,000 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 deductible expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> , services that charge a <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/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For Blue Choice Options: \$4,000 Individual / \$8,000 Family For In-Network: \$7,100 Individual / \$14,200 Family For Out-of-Network: \$16,000 Individual / \$32,000 Family Prescription drug expense limit: \$2,000 Individual / \$4,000 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.
What is not included in the out-of-pocket limit?	Premiums, <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> .
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-346-7072 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in <u>Blue Choice Option</u> . You pay more if you use a <u>provider in-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 (<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.
Do you need a referral to see a specialist?	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
		Blue Choice Options Provider (You will pay the least)	In-Network Provider (You will pay more)	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	\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Specialist visit	\$60 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive</u> care/screening/immunization	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <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>	50% <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.bcbsil.com	Generic drugs	\$20 <u>copay/prescription</u> (retail) \$40 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$20 <u>copay/prescription</u> (retail) \$40 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$20 <u>copay/prescription</u> (retail); <u>deductible</u> does not apply	34-day supply at Retail 90-day supply at Mail Order For maintenance medications you can get a 90-day supply through the Extended Supply Network.
	Preferred brand drugs	\$50 <u>copay/prescription</u> (retail) \$100 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$50 <u>copay/prescription</u> (retail) \$100 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$50 <u>copay/prescription</u> (retail); <u>deductible</u> does not apply	Rx Out-of-Pocket Expense Limit: \$2,000 Individual/\$4,000 Family For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the <u>copayment</u> .
	Non-preferred brand drugs	\$70 <u>copay/prescription</u> (retail) \$140 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$70 <u>copay/prescription</u> (retail) \$140 <u>copay/prescription</u> (mail order); <u>deductible</u> does not apply	\$70 <u>copay/prescription</u> (retail); <u>deductible</u> does not apply	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.
	Specialty drugs	\$70 <u>copay/prescription</u> (retail); <u>deductible</u> does not apply	\$70 <u>copay/prescription</u> (retail); <u>deductible</u> does not apply	Not Covered	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 www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Options Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your <u>benefit booklet*</u> for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</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>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your <u>benefit booklet*</u> for details.
	<u>Urgent Care</u>	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. See your <u>benefit booklet*</u> for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay/office visit</u> ; <u>deductible</u> does not apply and 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your <u>benefit booklet*</u> for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Options Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$40 PCP/\$60 SPC copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	Copay applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> 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 service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	50% coinsurance	None
	Home health care	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	50% coinsurance	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.
	Hospice services	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Options Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
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	None
	Children's dental check-up	Not Covered	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 (Adult) - Hearing aids - Long-term care	- Non-emergency care when traveling outside the U.S. - Routine eye care (Adult) - 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.)	
- Acupuncture - Bariatric surgery - Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year)	- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) - Infertility treatment (4 in vitro attempt maximum per lifetime) - Most coverage provided outside the United States. See www.bcbsil.com - Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits per calendar year)

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 1-800-346-7072, 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 1-800-346-7072 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 1-800-346-7072.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-346-7072.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-346-7072.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-346-7072.

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 Blue Choice Options pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- 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>	\$1,000
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$2,300
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,410

Managing Joe's Type 2 Diabetes

(a year of routine Blue Choice Options care of a well- controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- 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>	\$900
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

Mia's Simple Fracture

(Blue Choice Options emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- 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>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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, sexual orientation, health status 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, Illinois 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/portal/lobby.jsf Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html



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.

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, llame al 855-710-6984.
العربية Arabic	إن كل من لديك أو لدى شخص تساعدك، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 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，請撥電話號碼 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, appelez 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 Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બીજા વ્યક્તિને મદદ કરવામાં આવે છે, તો તમને વિના ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક છે. દુભાવિયા સાથે વાત કરવા માટે અમને 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपको, या आप जिसकी सहायता कर रहे हैं उससे, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 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 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. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ní, éí doodagó la'da bíká anáníłwo'ígíí, na'ídiłkíidgo, ts'ídá bee ná ahóóti'í' t'áá níik'e níká a'doolwoł dóó bina'ídiłkíidgíí bee níí h'oodoníh. Áta 'dahalne'ígíí bich'í' hodiilnít kwe'e 855-710-6984.
فارسی Persian	اگر شما یا کسی که شما به او کمک میکنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, 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 связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan 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 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسی فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے پر 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnameseese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.