



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/member/policy-forms/2017 or by calling 1-800-892-2803. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the plan pays for any services.
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?	Yes. Individual: Participating \$1,500 Family: Participating \$3,000 Prescription Drug expense limit: \$1,000 Individual \$3,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<u>Premiums</u> and health care this Plan 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 1-800-892-2803 for a list of Participating Providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. 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 plan 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?	Yes. You do need a <u>Referral</u> to see a <u>Specialist</u> .	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a referral before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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	\$30 <u>copayment</u> /visit	Not Covered	none
	<u>Specialist</u> visit	\$50 <u>copayment</u> /visit	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	No charge for immunizations. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	\$15/\$30 <u>copayment</u> /prescription	Not Covered	Dispensing limit may apply to certain drugs. Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. RX Out-of-Pocket Expense Limit: \$1,000 Individual/\$3,000 Family.
	Formulary brand drugs	\$30/\$60 <u>copayment</u> /prescription	Not Covered	
	Non-formulary brand drugs	\$50/\$100 <u>copayment</u> /prescription	Not Covered	
	Specialty drugs	Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	<u>Referral</u> required.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	\$150 <u>copayment</u> /visit	\$150 <u>copayment</u> /visit	<u>copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	No Charge	No Charge	none
	<u>Urgent care</u>	No Charge	Not Covered	Applicable <u>copayment</u> may apply. Must be affiliated with member's chosen medical group or <u>Referral</u> required.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<u>Referral</u> required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2017.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> /visit	Not Covered	Referral required.
	Inpatient services	No Charge	Not Covered	
If you are pregnant	Office visits	\$30 <u>copayment</u>	Not Covered	Copayment applies to first prenatal visit per pregnancy. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Referral required.
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	No Charge	Not Covered	Referral Required. 60 visits combined/calendar year. Includes, but is not limited to, physical, occupational or speech therapy. copayment may apply.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Referral required. Excludes custodial care.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Referral required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 exam every 12 months
	Children's glasses	Not Covered	Not Covered	none
	Children's dental check-up	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 | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery (unless <u>medically necessary</u>) | • Long-term care | • Private-duty nursing |
| • Cosmetic surgery | • Most coverage provided outside the United States. See www.bcbsil.com | • Weight loss programs |
| • Dental Care | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|--|---------------------------|--|
| • Chiropractic care | • Routine eye care(Adult) | • Routine foot care (Only in connection with diabetes) |
| • Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period) | | |

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 1-800-892-2803, 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 1-800-892-2803 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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): Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-2803.

—————*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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$50	■ Specialist copayment	\$50	■ Specialist copayment	\$50
■ Hospital (facility)	\$0	■ Hospital (facility)	\$0	■ Hospital (facility)	\$0
■ Other	\$0	■ Other	\$0	■ Other	\$0
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$7,400	Total Example Cost	\$2,000
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$100	Copayments	\$1,600	Copayments	\$200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$160	The total Joe would pay is	\$1,660	The total Mia would pay is	\$200

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