



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 of covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [www.bcbsil.com](http://www.bcbsil.com) or by calling 1-800-862-3386. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>In-Network:</b> \$1,200 / Individual; \$2,400 / Family <b>Out-of-Network:</b> \$2,400 / Individual; \$4,800 / Family	Generally, you must pay all 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 <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventative care</u> and Chiropractic 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>co-payment</u> or <u>co-insurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventative services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventative services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>In-Network Medical:</b> \$4,000/Individual; \$8,000/Family <b>Out-of-Network Medical:</b> \$8,400/Individual; \$16,800/Family <b>In-Network Prescription:</b> \$3,900/Individual; \$7,800/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 may have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	<b>Co-payments</b> for certain services, <b>premiums</b> , <b>balance-billed</b> charges, non-PPO <b>co-insurance</b> , penalties for failure to obtain <b>pre-authorization</b> for services, hearing aid <b>co-insurance</b> , and health care this <u>plan</u> does not 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 <u>network provider</u> ?	<b>Yes.</b> Visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider 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</u> charge and what your <u>plan</u> pays ( <b>balance billing</b> ). 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 <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **co-payments** and **co-insurance** costs shown in this chart are after your overall **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <b>copay</b> /visit	40% <b>coinsurance</b>	-----None-----
	<b>Specialist</b> visit	\$60 <b>copay</b> /visit	40% <b>coinsurance</b>	-----None-----
	<b>Preventive care/ screening/ immunization</b>	No charge	40% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services you need are preventive. Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	15% <b>coinsurance</b>	40% <b>coinsurance</b>	-----None-----
	Imaging (CT/PET scans, MRIs)	15% <b>coinsurance</b>	40% <b>coinsurance</b>	
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	Generic drugs	\$10/30-day prescription \$20/90-day prescription	Not Covered	You can obtain two initial 30-day fills of a maintenance drug at any retail pharmacy. After the two initial fills, you must obtain a 90-day fill via CVS Mail Order or CVS Pharmacy. Call 1-800-966-5772 for CVS Mail Order.  30-day supply for non-maintenance drugs can be filled at any in-network pharmacy.  <b>Specialty drugs</b> must be filled through CVS Specialty Connect at 1-800-237-2767.  <b>\$3,900/individual and \$7,800/family</b> annual max. <b>out-of-pocket limit</b> on in-network prescriptions.  Call CVS at 1-800-566-5693 for customer service.
	Preferred brand drugs	25% of cost; \$35 min/\$50 max copay/30-day prescription. 25% of cost; \$70 min/\$100 max/90-day prescription.	Not Covered	
	Non-preferred brand drugs	30% of cost; \$55 min/\$100 max/30-day prescription. 30% of cost; \$110 min/\$200 max/90-day prescription.	Not Covered	
	<b>Specialty drugs</b>	<b>Preferred Brand Specialty:</b> 25% of cost; \$35 min/\$50 max copay/30-day prescription. 25% of cost; \$70 min/\$100 max/90-day prescription. <b>Non-Preferred Brand Specialty:</b> 30% of cost; \$55 min/\$100 max/30-day prescription. 30% of cost; \$110 min/\$200 max/90-day prescription.	Not Covered	

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)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	-----None-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> will result in a \$200 penalty. Non-emergency admissions must be preauthorized a minimum of 3 days prior to treatment. Emergency admissions must be authorized within 48 hours. Childbirth: Preauthorization is required for extended hospital stays that exceed 48 hours/vaginal delivery; 96 hours/cesarean section. Call BCBSIL Medical Service Advisory at 1-800-635-1928 for further information.</p>
	Physician/surgeon fee	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25.00 <u>copay</u> /office visit	40% <u>coinsurance</u>	<p><u>Preauthorization</u> is required for inpatient services. Failure to obtain <u>preauthorization</u> may result in a \$200 penalty. Non-emergency admissions must be <u>preauthorized</u> a minimum of 3 days prior to treatment. Emergency admissions must be authorized within 48 hours. Prior to inpatient mental health or substance abuse care, call BCBSIL Behavioral Health at 1-800-851-7498. Member's Assistance Program (MAP), call ERS at 1-800-292-2780.</p>
	Inpatient services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office Visits	\$25.00 copay/office visit	40% <u>coinsurance</u>	<p>Copay only applies to first prenatal visit/ pregnancy. <u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, coinsurance may apply.</p>
	Childbirth/delivery professional services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	

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>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Medical review required. Call BCBSIL 1-800-862-3386.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL at 1-800-862-3386.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL 1-800-862-3386.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Medical review required. Call BCBSIL 1-800-862-3386.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. Some <b>durable medical equipment (DME)</b> may require medical review. Call BCBSIL at 1-800-862-3386.
	<u>Hospice services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Medical review required. Life expectancy must be 6 months or less. Call BCBSIL at 1-800-862-3386.
If your child needs dental or eye care	Children's eye exam	No charge for child age 0-18 \$30.00 <u>copay</u> for child age 19-26	\$30.00 <u>copay</u>	Child must be an Eligible Dependent under Plan. <b>Out-of-Network:</b> Child age 19-26, Plan will reimburse up to \$45 on one exam per year after the copay is satisfied. Call VSP at 1-800-877-7195.
	Children's glasses	\$20.00 <u>copay</u>	\$20.00 <u>copay</u> + 20% <u>coinsurance</u> for child age 0-18	Child must be an Eligible Dependent under Plan. <b>In-Network:</b> Child age 19-26, is responsible for frame costs above \$125, but discounted by 20%. <b>Out-of-Network:</b> Child age 19-26, reimbursement up to specified limits depending on the type of lens and frame. Call VSP at 1-800-877-7195.
	Children's dental check-up	No charge for child age 0-26	No charge for child age 0-26, unless over U&C charges	Child must be an Eligible Dependent under Plan. No charge applies to eligible preventative care services. <b>Child age 0-18:</b> Preventative care services <u>do not</u> apply to dental maximum. <b>Child age 19-26:</b> Preventative care services <u>do</u> apply to dental maximum. Call Dental Network of America at 1-800-862-3386.

**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.)**

- Bariatric surgery (except in cases of morbid obesity)
- Cosmetic surgery (unless corrects the effect of an injury, congenital deformity or deformity resulting from disease or is medically necessary)
- Infertility treatment
- Long-term care
- Weight loss programs (except in cases of morbid obesity)

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

- Acupuncture (30 visit limit/calendar year)
- Chiropractic care (30 visit limit/calendar year)
- Dental Care (Adult)
- Hearing aids (\$75 exam, 80% of first \$500 of U&C charges per ear; \$400 maximum/calendar year); limits do not apply to bone anchored hearing aids for eligible dependent children age 0-19).
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com)
- Non-emergency care when traveling outside the United States
- Private-duty nursing (except inpatient private duty nursing)
- Routine eye care (Adult)
- Routine foot care (when determined to be medically necessary)

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help you 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 information about your rights, this notice, or assistance, contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 1-800-862-3386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-3386.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-862-3386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-862-3386.

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





**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 the 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 \$1,200
- Specialist copayment \$60
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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- Specialist copayment \$60
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

**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*)

**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*)

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services

<b>Total Example Cost</b>	<b>\$12,800</b>
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<b>Total Example Cost</b>	<b>\$7,400</b>
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<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copays	\$100
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,700</b>

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copays	\$1,100
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,460</b>

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$900
Copays	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

