



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 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.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?	\$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. \$1,500 Individual/\$3,000 Family Prescription drug expense limit: \$1,000 Individual/\$2,000 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 plan, 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 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 network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 charge</u> 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.	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 <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (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>copay</u> /visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care <u>Provider</u> , except emergency and routine vision exams, are not covered.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>Provider</u> if the services needed 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 www.bcbsil.com	Generic drugs	\$20 <u>copay</u> /prescription (retail) \$40 <u>copay</u> /prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 34 day retail/90 day mail. RX Out-of-Pocket Expense Limit: \$1,000 Individual/\$2,000 Family
	Preferred brand drugs	\$40 <u>copay</u> /prescription (retail) \$80 <u>copay</u> /prescription (mail order)	Not Covered	
	Non-preferred brand drugs	\$70 <u>copay</u> /prescription (retail) \$140 <u>copay</u> /prescription (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$20/\$40/\$70 <u>copay</u> /prescription (retail)	Not Covered	Coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30 day supply.
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	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No Charge	No Charge	Ground transportation only.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	Not Covered	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.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> / visit	Not Covered	Unlimited visits.
	Inpatient services	No Charge	Not Covered	<u>Referral</u> required.
If you are pregnant	Office visits	\$30 <u>copay</u> PCP/ \$50 <u>copay</u> SPC	Not Covered	<u>Copay</u> applies for the 1st prenatal visit only. <u>Cost Sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> 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	
	Childbirth/delivery facility services	No Charge	Not Covered	<u>Referral</u> required.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Not Covered	<u>Referral</u> required.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	Not Covered	60 visits combined for all therapies.
	<u>Habilitation services</u>	\$30 <u>copay</u> /visit	Not Covered	<u>Referral</u> required.
	<u>Skilled nursing care</u>	No Charge	Not Covered	Excludes custodial care. <u>Referral</u> required.
	<u>Durable medical equipment</u>	No Charge	Not Covered	<u>Referral</u> required. 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>Hospice services</u>	No Charge	Not Covered	<u>Referral</u> required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating Providers.
	Children's glasses	No Charge	Not Covered	\$175 allowance every 24 months at participating Providers.
	Children's dental check-up	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.)

- Custodial care services
- Dental care (Adult and Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (1 per ear every 24 months)
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult and Children)
- Routine foot care (Only in connection with diabetes)
- Weight loss programs (except when non-medically supervised)

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: For group health coverage contact the plan Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com. For group health coverage subject to ERISA contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: 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

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 1-800-892-2803.

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, kwijjigo 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: <u>Specialist office visits (prenatal care)</u> <u>Childbirth/Delivery Professional Services</u> <u>Childbirth/Delivery Facility Services</u> <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u>		This EXAMPLE event includes services like: <u>Primary care physician office visits (including disease education)</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u>		This EXAMPLE event includes services like: <u>Emergency room care (including medical supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$40	Copayments	\$900	Copayments	\$400
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$100	The total Joe would pay is	\$920	The total Mia would pay is	\$400

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

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called BCBSIL)
SBC IL HMO LG-2025



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Health care coverage is important for everyone.

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. 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. 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, IL 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/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاًاً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	855-710-6984 પર કોલ કરીને અમે તમને મુક્તિ મળે છે.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
□□□	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1 haz'1. 1-866-560-4042 j8 hod7lni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.