**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/2025 or by calling 1-800-541-2768. 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?** | Individual: Participating $2,500<br>Non-Partcipating $5,000<br>Family is equivalent to 3 individuals. | 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Doesn't apply to certainpreventive care. Copayments and per occurrence deductibles don't count toward the 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 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?** | Yes. Individual:<br>Participating $2,000<br>Non-Partcipating $4,000<br>Family is equivalent to 3 individuals. | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | Copayments, deductible, premiums, balance billed 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?** | See **www.bcbsil.com** or call **1-800-541-2768** for a list of Participating 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). 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 |
|---|---|---|---|---|
| | | 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 copayment/visit | 40% coinsurance | No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary. |
| | Specialist visit | $50 copayment/visit | 40% coinsurance | none |
| | Preventive care/screening/ immunization | No Charge | 40% coinsurance | 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 plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | none |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at https://www.bcbsil.com/rx-drugs/drug-lists/drug-lists | Generic drugs | $15/$30 copayment/ prescription | $15 copayment/ prescription | Up to 30 day retail /90 day home delivery. 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. For Non-Participating drug provider you are responsible for 25% of the eligible amount after the copayment. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Specialty retail /home delivery limited to 30 day supply except for certain FDA-designated dosing regimens. The amount you may pay per 30 day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $100, when obtained from a Preferred Participating or Participating Pharmacy. |
| | Preferred brand drugs | $30/$60 copayment/ prescription | $30 copayment/ prescription | |
| | Non-preferred brand drugs | $50/$100 copayment/ prescription | $50 copayment/ prescription | |
| | Specialty drugs | Covered | Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | none |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |

| 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 need immediate medical attention** | Emergency room care | $150 copayment/visit | $150 copayment/visit | Copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | none |
| | Urgent care | 20% coinsurance | 40% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | $300 copayment/ visit plus 40% coinsurance | none |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copayment/visit or 20% coinsurance | 40% coinsurance | Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. |
| | Inpatient services | 20% coinsurance | $300 copayment/ visit plus 40% coinsurance | none |
| **If you are pregnant** | Office visits | $30 copayment | 40% coinsurance | Copayment applies to first prenatal visit per pregnancy.Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 40% coinsurance | 40% coinsurance | none |
| | Childbirth/delivery facility services | 20% coinsurance | $300 copayment/ visit plus 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | none |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | 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 | 20% coinsurance | 40% coinsurance | none |

| 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 your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | none |
| | Children's glasses | Not Covered | Not Covered | |
| | 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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs

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

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Only in connection with 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: 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, kwiijigo 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)

| | |
|---|---|
| **The plan's overall deductible** | $2,500 |
| **Specialist copayment** | $50 |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $30 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,090** |

### 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 copayment** | $50 |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | $2,500 |
| **Specialist copayment** | $50 |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,000** |

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