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 1-866-266-3674 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-866-266-3674 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For Home Hospital and In-Network: $500 Person/ $1,000 Family&lt;br&gt;For Out-of-Network: $1,000 Person/ $2,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain preventive care and emergency room services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Retail RX: $100 deductible per person/$200 family for preferred and non-preferred brand drugs</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For Home Hospital and In-Network: $3,000 Person/ $6,000 Family&lt;br&gt;For Out-of-Network: $6,000 Person/ $12,000 Family</td>
<td>The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balanced-billed charges, prescription drug charges, and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-866-266-3674 for a list of network providers.</td>
<td>You pay the least if you use a provider in Loyola Hospital. You pay more if you use a provider in-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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Home Hospital Provider (You will pay the least)</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
<td>50% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Home Hospital Provider (You will pay the least)</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider (You will pay the most)</td>
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</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Covered at 85%, you pay 15% to a maximum of $200 per script Mail Order Covered at 95%, you pay 5% to a maximum of $400 per script</td>
<td>Covered at 85%, you pay 15% to a maximum of $200 per script Mail Order Covered at 95%, you pay 5% to a maximum of $400 per script</td>
<td>Covered at 85%, you pay 15% to a maximum of $200 per script Mail Order Covered at 95%, you pay 5% to a maximum of $400 per script</td>
<td>In Network: $100 Deductible Per Person/$200 Family. Mail Order - Deductible does not apply. 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 CVS/Caremark. Retail: 1 copay per 30 day supply. Benefits will be provided at 75% of the amount you would have received had you obtained drugs from a participating provider. RX Out-of-Pocket Expense Limit: $3,000 Person/$6,000 Family. Prior authorization and step therapy may apply.</td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Covered at 70%; you pay 30% to a maximum of $200 per script Mail Order Covered at 85%, you pay 15% to a maximum of $400 per script</td>
<td>Covered at 70%; you pay 30% to a maximum of $200 per script Mail Order Covered at 85%, you pay 15% to a maximum of $400 per script</td>
<td>Covered at 70%; you pay 30% to a maximum of $200 per script Mail Order Covered at 85%, you pay 15% to a maximum of $400 per script</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Covered at 55%, you pay 45% to a maximum of $400 per script Mail Order Covered at 75%, you pay 25% to a maximum of $400 per script</td>
<td>Covered at 55%, you pay 45% to a maximum of $400 per script Mail Order Covered at 75%, you pay 25% to a maximum of $400 per script</td>
<td>Covered at 55%, you pay 45% to a maximum of $400 per script Mail Order Covered at 75%, you pay 25% to a maximum of $400 per script</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Prior Authorization and step therapy may apply</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient</td>
<td>Facility fee (e.g., ambulatory) 10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>surgery</td>
<td>surgery center)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$150 copay/visit; deductible does not apply</td>
<td>$150 copay/visit; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).
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</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
<td>$500/admit plus 50% coinsurance</td>
<td>Program deductible waived for Home Hospital facility.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>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).</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>$100/admit plus 10% coinsurance</td>
<td>$250/admit plus 20% coinsurance</td>
<td>$500/admit plus 50% coinsurance</td>
<td>Program deductible waived for Home Hospital facility.</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

- Children's eye exam: No Charge
- Children's glasses: Not Covered
- Children's dental check-up: 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.)**

- Cosmetic surgery
- Dental care (Adult and Children)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- 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
- Infertility treatment
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com).
- Private-duty nursing (with the exception of inpatient private duty nursing)
- Routine eye care (Adult and Children)

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).
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 1-866-266-3674, 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 1-866-266-3674 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): Para obtener asistencia en Español, llame al 1-866-266-3674.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-266-3674.
Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 1-866-266-3674.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible $500</td>
<td>The plan’s overall deductible $500</td>
<td>The plan’s overall deductible $500</td>
</tr>
<tr>
<td>Specialist coinsurance 10%</td>
<td>Specialist coinsurance 10%</td>
<td>Specialist coinsurance 10%</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 10%</td>
<td>Hospital (facility) coinsurance 10%</td>
<td>Hospital (facility) coinsurance 10%</td>
</tr>
<tr>
<td>Other coinsurance 10%</td>
<td>Other coinsurance 10%</td>
<td>Other coinsurance 10%</td>
</tr>
</tbody>
</table>

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 $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $60
- The total Peg would pay is $1,860

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 $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $60
- The total Joe would pay is $2,060

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 $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $60
- The total Mia would pay is $800

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).
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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don’t have a card, call 855-710-6884.

bcbsil.com
**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 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.

<table>
<thead>
<tr>
<th>Office of Civil Rights Coordinator</th>
<th>Phone:</th>
<th>855-664-7270 (voicemail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 E. Randolph St.</td>
<td>TTY/TDD:</td>
<td>855-661-6965</td>
</tr>
<tr>
<td>35th Floor</td>
<td>Fax:</td>
<td>855-661-6960</td>
</tr>
<tr>
<td>Chicago, Illinois 60601</td>
<td>Email:</td>
<td><a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></td>
</tr>
</tbody>
</table>

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

<table>
<thead>
<tr>
<th>U.S. Dept. of Health &amp; Human Services</th>
<th>Phone:</th>
<th>800-368-1019</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 Independence Avenue SW</td>
<td>TTY/TDD:</td>
<td>800-537-7697</td>
</tr>
<tr>
<td>Room 509F, HHH Building 1019</td>
<td>Complaint Portal:</td>
<td><a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsp">https://ocrportal.hhs.gov/ocr/portal/lobby.jsp</a></td>
</tr>
</tbody>
</table>