**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/att. 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 1-877-722-0020 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Medical, including Mental Health (MH/SUD), Rx and CarePlus; For Indiv and Fam; Network: $1,600/$3,200; **Non-Network**: $4,800/$9,600 | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Network Preventive care services are covered before you meet your 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 https://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?** | Medical, including MH/SUD, Rx and CarePlus; For Indiv and Fam; Network: $6,650/$13,300; **Non-Network**: $19,950/$39,900; Capped at the Indiv Out-of-Pocket amount above for each Indiv participant during the applicable Plan yr. | 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. |
| **What is not included in the out-of-pocket limit?** | Amounts that exceed allowable charges for eligible expenses, Balance-billing charges, Contributions, Health care this plan doesn't cover, Ineligible expenses, Non-Network Charges paid by the Participant (Only Allowable Charges apply), Notice or preauthorization penalties, Premiums | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. For a list of network providers, see www.bcbsil.com/att or call 1-800-621-7336. | 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 |
|---|---|---|---|---|
| | | Network (You will pay the least) | Non-Network (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 | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Specialist visit | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Preventive care/screening/immunization | 0% Coinsurance | Not covered | Annual Deductible does not apply. 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Imaging (CT/PET scans, MRIs) | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network (You will pay the least) | Non-Network (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at 1-800-378-8851 or www.caremark.com. | Generic drugs | Retail: $10 Copay/Rx after deductible; Mail Order: $20 Copay/Rx after deductible; Annual Deductible and Copay do not apply to Preventive Care Drugs | You pay the Network Retail Copay or 25% of the Network Retail Cost, whichever is greater, plus any amount the Pharmacy charges above the Network Retail Cost | Retail: Up to a 30-day supply; limited to two (2) Fills for maintenance Rxs then must use Mail Order. Mail Order: Up to a 90-day supply; subject to the Specialty Rx provisions |
| | Preferred brand drugs | Retail: $40 Copay/Rx after deductible; Mail Order: $80 Copay/Rx after deductible; Annual Deductible and Copay do not apply to Preventive Care Drugs | See Generic Drugs | Retail: Up to a 30-day supply; limited to two (2) Fills for maintenance Rxs then must use Mail Order. Mail Order: Up to a 90-day supply; subject to the Specialty Rx provisions |
| | Non-preferred brand drugs | Retail: $80 Copay/Rx after deductible; Mail Order: $160 Copay/Rx after deductible; Annual Deductible and Copay do not apply to Preventive Care Drugs | See Generic Drugs | Retail: Up to a 30-day supply; limited to two (2) Fills for maintenance Rxs then must use Mail Order. Mail Order: Up to a 90-day supply; subject to the Specialty Rx provisions |
| | Specialty drugs | Covered, refer to Copays above | Covered, refer to Copays above | Retail: Must be filled through the Rx Benefits Administrator's Specialty Pharmacy after the first Fill at retail |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| | Physician/surgeon fees | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network (You will pay the least) | Non-Network (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 10% Coinsurance after Annual Deductible | 10% Coinsurance after Annual Deductible | ——————none—————— |
| | Emergency medical transportation | 10% Coinsurance after Annual Deductible | 10% Coinsurance after Annual Deductible | ——————none—————— |
| | Urgent care | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| | Physician/surgeon fee | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| | Inpatient services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| **If you are pregnant** | Office visits | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| | Childbirth/delivery professional services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |
| | Childbirth/delivery facility services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network (You will pay the least) | Non-Network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Rehabilitation services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | Maintenance therapy is not to exceed two sessions/month up to 24 sessions/calendar yr. The patient is allowed two sessions of each type of therapy (physical, occupational and speech). |
| | Habilitation services | Not covered | Not covered | ————————none———————— |
| | Skilled nursing care | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Durable medical equipment | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| | Hospice services | 10% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible | ————————none———————— |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | ————————none———————— |
| | Children's glasses | Not covered | Not covered | ————————none———————— |
| | 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care - adult (Except for accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult
- Routine foot care (Except for diabetes)
- Weight loss programs (Unless covered by preventive care (e.g. nutritional counseling) or a wellbeing program specifically provided under the plan)

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

- Bariatric surgery (Must meet medical guidelines)
- Chiropractic care (Visit limits apply)
- Hearing aids (Limited exceptions apply)
- Private-duty nursing (Notification required)

**For additional limitations and requirements, such as visit limits and preauthorization, refer to the SPD.**

**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: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or you may contact the plan at 1-877-722-0020. 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 on how 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 1-800-621-7336.

**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 1-877-722-0020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-722-0020.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-722-0020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-722-0020.

*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 | $1600 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $1,600 |
| Copayments | $10 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,770** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1600 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $1,600 |
| Copayments | $500 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,170** |

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

| | |
|---|---|
| The plan's overall deductible | $1600 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $1,600 |
| Copayments | $10 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Mia would pay is** | **$1,750** |

Note: These numbers assume the patient does not participate in the plan's wellbeing program. If you participate in the plan's wellbeing program, you may be able to reduce your costs. For more information about the wellbeing program, please contact: 1-800-621-7336.

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