
 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.bmousbenefits.com](http://www.bmousbenefits.com) or call 1-888-927-7700. 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 <http://www.healthcare.gov/sbc-glossary/> or call 1-888-927-7700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">in-network providers</a> \$1,750/Individual or \$3,500/family; for <a href="#">out-of-network providers</a> \$3,500 individual/ \$7,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> \$3,425 individual / \$6,850 family; for <a href="#">out-of-network providers</a> \$6,850 individual / \$13,700 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limits</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, prescription drugs this plan doesn't cover, and recertification penalties.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-888-979-4516 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Virtual visits may be available, please refer to your <a href="#">plan</a> policy for more details.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	You may have to pay for services that aren't <a href="#">Preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required; call the number on back of your ID card for details.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com/bmofinancialgroup">www.express-scripts.com/bmofinancialgroup</a> or by calling member services at 1-877-795-2926.	Generic	\$10 <a href="#">copay</a> /prescription-retail \$20 <a href="#">copay</a> /prescription-mail (31-90)	Same as in-network, retail pricing applies. Mail order not covered.	Retail prescriptions limited to a 30-day supply or 90-day maintenance drug available at most retail pharmacies at 3 times the monthly retail copay/coinsurance amount. Mail order available for 31-90 day supply. Subject to deductible (some exclusions apply).  Infertility medications lifetime limit of \$40,000.  The Dispense as Written (DAW1&2) program requires you to use a generic equivalent drug when available. If you choose to purchase a brand drug when a generic equivalent is available, you pay the generic copayment plus the difference in cost between the brand and the generic. Extra cost will not apply toward deductible or out-of-pocket maximum.
	<a href="#">Formulary</a>	25% <a href="#">coinsurance</a> /prescription min \$20, max \$50-retail 25% <a href="#">coinsurance</a> /prescription min \$40, max \$100-mail (31-90 day)		
	Nonformulary	35% <a href="#">coinsurance</a> /prescription min \$40, max \$70-retail 35% <a href="#">coinsurance</a> /prescription min \$80, max \$140-mail (31-90 day)		
	<a href="#">Specialty drugs</a>	Based on category (generic, <a href="#">Formulary</a> , Nonformulary)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required; call the number on back of your ID card for details.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bmousbenefits.com](http://www.bmousbenefits.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> and \$100 copay	40% <a href="#">coinsurance</a> and \$100 copay	Copay waived if admitted. In-network benefits apply if considered an emergency. <a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify admission.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required; call the number on back of your ID card for details. Penalty of \$400 for failure to precertify inpatient services. Virtual visits may be available.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. <a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify extended lengths of stay for mother or newborn over 48 hours for vaginal delivery or 96 hours for cesarean section.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Up to 120 visits per calendar year. <a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Up to 60 combined visits for physical, occupational, and speech therapies. <a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Up to 60 days per confinement per calendar year. <a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. Penalty of \$400 for failure to precertify.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Penalty of \$400 for failure to precertify.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Visual Acuity Screening only, no charge if preventive.
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bmousbenefits.com](http://www.bmousbenefits.com).

## 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) (certain exceptions apply)
- Long Term Care
- Routine foot care (certain exceptions apply)
- Weight loss programs

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

- Acupuncture (20 visits per calendar year)
- Bariatric Surgery
- Chiropractic Care (20 visits per calendar year)
- Hearing Aids
- Infertility treatment (fertility preservation when **Medically Necessary**)
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 Customer Service at 1-888-979-4516 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your **appeal**. Visit <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/> for a list of state consumer assistance programs.

**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 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 1-888-927-7700.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-927-7700.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-927-7700.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-927-7700.]

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

\* For more information about limitations and exceptions, see the **plan** or policy document at [www.bmousbenefits.com](http://www.bmousbenefits.com).

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](#) \$1750
- [Specialist coinsurance](#) 20%
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$1,675
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,485</b>

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

- The [plan's overall deductible](#) \$1750
- [Specialist coinsurance](#) 20%
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$100
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,770</b>

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

- The [plan's overall deductible](#) \$1750
- [Specialist copayment](#) 20%
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$10
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,960</b>