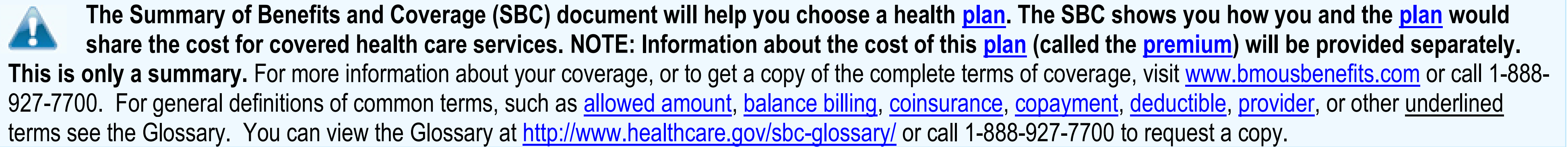
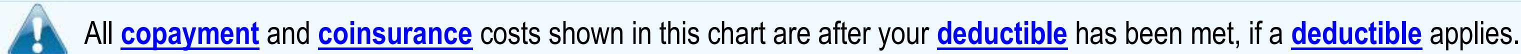


**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bmousbenefits.com 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 deductible?** | For in-network providers $1,750/Individual or $3,500/family; for out-of-network providers $3,500 individual/ $7,000 family | 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?** | Yes. Preventive care is 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?** | For in-network providers $3,425 individual / $6,850 family; for out-of-network providers $6,850 individual / $13,700 family | 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, the overall family out-of-pocket limits must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, prescription drugs this plan doesn't cover, and precertification penalties. | 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?** | Yes. See www.bcbsil.com or call 1-888-979-4516 for a list of network 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. |




| 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 visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 40% coinsurance | Virtual visits may be available, please refer to your plan policy for more details. |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 40% coinsurance, deductible does not apply | 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 | Preauthorization may be required; call the number on back of your ID card for details. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com/bmofinancialgroup or by calling member services at 1-877-795-2926. | Generic | $10 copay/prescription-retail $20 copay/prescription-mail (31-90) | Same as in-network, retail pricing applies. Mail order not covered. | Smart90 requires you to fill maintenance medications at a Smart90 retailer (Walgreens or CVS) or through ESI home delivery. You can get two retail 30 day grace fills for maintenance medications.<br>Infertility medications lifetime limit of $40,000.<br>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. |
| | Formulary | 25% coinsurance/ prescription min $20, max $50-retail 25% coinsurance/ prescription min $40, max $100-mail (31-90 day) | | |
| | Nonformulary | 35% coinsurance/ prescription min $40, max $70-retail 35% coinsurance/ prescription min $80, max $140-mail (31-90 day) | | |
| | Specialty drugs | Based on category (generic, Formulary, Nonformulary) | Not covered. | Required to be filled through Express Script's specialty mail order pharmacy, Accredo Health Group, Inc. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Preauthorization may be required; call the number on back of your ID card for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical** | Emergency room care | 20% coinsurance and $100 copay | 40% coinsurance and $100 copay | Copay waived if admitted. In-network benefits apply if considered an emergency. |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| **attention** | Emergency medical transportation | 20% coinsurance | 40% coinsurance | Preauthorization required. Penalty of $400 for failure to precertify admission. |
| | Urgent care | 20% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required. Penalty of $400 for failure to precertify. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance | Preauthorization 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% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Preauthorization 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% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Up to 120 visits per calendar year. Preauthorization required. Penalty of $400 for failure to precertify. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Up to 60 combined visits for physical, occupational, and speech therapies. Preauthorization required. Penalty of $400 for failure to precertify. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Up to 60 days per confinement per calendar year. Preauthorization required. Penalty of $400 for failure to precertify. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Preauthorization may be required. Penalty of $400 for failure to precertify. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Preauthorization required. Penalty of $400 for failure to precertify. |
| **If your child needs dental or eye care** | Children's eye exam | 20% coinsurance | 40% coinsurance | Visual Acuity Screening only, no charge if preventive. |
| | 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.

## 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<br>• Dental Care (Adult) (certain exceptions apply) | • Long Term Care<br>• 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)<br>• Bariatric Surgery<br>• Chiropractic Care (20 visits per calendar year) | • Hearing Aids<br>• Infertility treatment (fertility preservation when Medically Necessary)<br>• Most coverage provided outside the United States. See www.bcbsil.com | • Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing<br>• 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, or the U.S. Department of Health and Human Services 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 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. 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, kwiijigo 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.

## 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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $0 |
| Coinsurance | $1,675 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,485** |

### 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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $100 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,770** |

### 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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,750 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,960** |