**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 1-866-390-7772 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 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?** | For The University of Chicago Medical Center: $300 Individual / $600 Family<br>In-Network and Out-of-Network: $500 Individual / $1,000 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 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?** | Yes. Certain 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 www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $200 deductible for Out-of-Network hospital admission. There are no other specific deductibles. | 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. |
| **What is the out-of-pocket limit for this plan?** | For The University of Chicago Medical Center: $1,750 Individual / $3,500 Family<br>In-Network and Out-of-Network: $2,500 Individual / $5,000 Family<br>Prescription drug expense limit: $2,000 Individual/$4,000 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, 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?** | Prescription copay, Premiums, balance-billing 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?** | Yes. See www.bcbsil.com or call 1-866-390-7772 for a list of network providers. | You pay the least if you use a provider in The University of Chicago Medical Center. 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. |
| **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 |
|---|---|---|---|---|---|
| | | UCMC Provider (You will pay the least) | In-Network Provider (You will pay more) | 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 | 10% coinsurance | 20% coinsurance | 35% coinsurance | Teladoc virtual visits: 20% coinsurance/visit; deductible applies. See your benefit booklet* for details. |
| | Specialist visit | 10% coinsurance | 20% coinsurance | 35% coinsurance | None |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | No Charge; deductible does not apply | No Charge; 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 | 20% coinsurance | 35% coinsurance | Preauthorization may be required; see your benefit booklet* for details. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 20% coinsurance | 35% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | UCMC Provider (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caremark.com or 866-873-8632. | Generic drugs | $10 copay/ prescription (Retail)<br><br>$20 copay/ prescription (Mail order). | $10 copay/ prescription (Retail)<br><br>$20 copay/ prescription (Mail order). | $10 copay/ prescription (Retail)<br><br>$20 copay/ prescription (Mail order) | RX Out-of-Pocket Expense Limit: $2,000 Individual/$4,000 Family<br><br>Dispensing limits may apply to certain drugs. |
| | Preferred brand drugs | $30 copay/ prescription (Retail)<br><br>$60 copay/ prescription (Mail order) | $30 copay/ prescription (Retail)<br><br>$60 copay/ prescription (Mail order) | $30 copay/ prescription (Retail)<br><br>$60 copay/ prescription (Mail order) | |
| | Non-preferred brand drugs | $50 copay/ prescription (Retail)<br><br>$100 copay/ prescription (Mail order) | $50 copay/ prescription (Retail)<br><br>$100 copay/ prescription (Mail order) | $50 copay/ prescription (Retail)<br><br>$100 copay/ prescription (Mail order) | |
| | Specialty drugs | 30% Coinsurance (Retail); $0 Copay if you enroll in the copay coupon program through CVS Caremark | 30% Coinsurance (Retail); $0 Copay if you enroll in the copay coupon program through CVS Caremark | 30% Coinsurance (Retail); $0 Copay if you enroll in the copay coupon program through CVS Caremark | Prior authorization may be required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 35% coinsurance | Preauthorization may be required; see your benefit booklet* for details. |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 35% coinsurance | None |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | UCMC Provider (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | Facility Charges: 10% coinsurance<br>ER Physician Charges: 10% coinsurance | Facility Charges: 20% coinsurance<br>ER Physician Charges: 20% coinsurance | Facility Charges: 20% coinsurance<br>ER Physician Charges: 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | 20% coinsurance | Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details. Limited to local ground or air transportation. |
| | Urgent care | 10% coinsurance | 20% coinsurance | 35% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 20% coinsurance | 35% coinsurance | Preauthorization required. See your benefit booklet* for details. $200 deductible per admission Out-of-Network providers. |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 35% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 20% coinsurance | 35% coinsurance | Preauthorization required; see your benefit booklet* for details. Teladoc virtual visits: 20% coinsurance/visit; deductible applies. See your benefit booklet* for details. |
| | Inpatient services | 10% coinsurance | 20% coinsurance | 35% coinsurance | $200 deductible per admission Out-of-Network providers. Preauthorization required. |
| **If you are pregnant** | Office visits | 10% coinsurance | 20% coinsurance | 35% coinsurance | Covered at 100% after deductible at UCMC. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No Charge | 20% coinsurance | 35% coinsurance | |
| | Childbirth/delivery facility services | No Charge | 20% coinsurance | 35% coinsurance | Covered at 100% after deductible at UCMC. $200 deductible per admission Out-of-Network providers. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | UCMC Provider (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge | No Charge | Limited to 120 visits per benefit period. Precertification required. Preauthorization may be required. |
| | Rehabilitation services | 10% coinsurance | 20% coinsurance | 35% coinsurance | Limited to 60 visits combined per calendar year for occupational therapy, speech therapy and physical therapy. Preauthorization may be required. |
| | Habilitation services | 10% coinsurance | 20% coinsurance | 35% coinsurance | |
| | Skilled nursing care | No Charge | No Charge | No Charge | Limited to 120 days per benefit period. Precertification required. Preauthorization may be required. |
| | Durable medical equipment | 10% coinsurance | 20% coinsurance | 35% coinsurance | Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required. |
| | Hospice services | No Charge | No Charge | No Charge | Preauthorization may be required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | 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
- Dental care (Adult)
- Infertility treatment (Fertility treatments are administered through Progyny. Please call (866) 960-4029 to activate benefits.)
- Long-term care
- Routine eye care (Adult)
- 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.)**

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 20 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (for children1 per ear every 24 months, for adults up to $2,500 per ear every 24 months)
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits per calendar year)

**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 1-866-390-7772, 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 1-866-390-7772 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 1-866-390-7772.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-390-7772.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-390-7772.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-390-7772.

***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 UCMC pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **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 | $300 |
| Copayments | $10 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,570** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **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 | $300 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,020** |

### Mia's Simple Fracture
(UCMC emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **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 | $300 |
| Copayments | $10 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$610** |

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

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

**Health care coverage is important for everyone.**

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 talk to an interpreter, call 855-710-6984. 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, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

| | **To receive language or communication assistance free of charge, please call us at 855-710-6984.** |
|---|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |