



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

S506OPT Blue Options Silver PPO<sup>SM</sup> 104 – Rx Copays



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/bb/grp/bb\\_spsq10bcosilo\\_il\\_2025.pdf](http://www.bcbsil.com/bb/grp/bb_spsq10bcosilo_il_2025.pdf) or by calling 1-800-541-2768. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Individual: Blue Choice \$5,350; PPO \$6,350; Out-of-Network \$12,700 Family: Blue Choice \$16,050; PPO \$18,200; Out-of-Network \$36,400	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. In-Network Preventive Health Care services, some services with a <u>copayment</u> , and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Individual: Blue Choice \$8,400; PPO \$9,200; Out-of-Network Unlimited Family: Blue Choice \$18,400; PPO \$18,400; Out-of-Network Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com/blueoptions">www.bcbsil.com/blueoptions</a> or call 1-800-541-2768 for a list of <u>Participating Providers</u> .	You pay the least if you use a <u>provider</u> in Blue Choice. You pay more if you use a <u>provider</u> in PPO <u>Provider</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your network <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$55/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits: \$55/visit; <u>deductible</u> does not apply. See your benefit booklet* for details.
	<u>Specialist</u> visit	\$80/visit; <u>deductible</u> does not apply	\$120/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsil.com/rx25/6T">www.bcbsil.com/rx25/6T</a></p>	Generic drugs (Preferred)	Retail - Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail - \$45/prescription; <u>deductible</u> does not apply	Retail - Preferred - \$15/prescription Non-Preferred - \$25/prescription Mail - \$45/prescription; <u>deductible</u> does not apply	\$25/prescription; <u>deductible</u> does not apply	<p>Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Any differences between the cost of the generic drug and the cost of the brand name drug will apply to the <u>deductible</u> or out-of-pocket maximum. The applicable <u>cost sharing</u> (by tier) and the cost difference between the generic and brand will never exceed the overall cost of the drug. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable <u>copayment/coinsurance</u>. Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained from a Preferred Participating or Participating Pharmacy.</p>
	Generic drugs (Non-Preferred)	Retail - Preferred - \$25/prescription Non-Preferred - \$35/prescription Mail - \$75/prescription; <u>deductible</u> does not apply	Retail - Preferred - \$25/prescription Non-Preferred - \$35/prescription Mail - \$75/prescription; <u>deductible</u> does not apply	\$35/prescription; <u>deductible</u> does not apply	
	Brand drugs (Preferred)	Retail - Preferred - \$60/prescription Non-Preferred - \$80/prescription Mail - \$180/prescription; <u>deductible</u> does not apply	Retail - Preferred - \$60/prescription Non-Preferred - \$80/prescription Mail - \$180/prescription; <u>deductible</u> does not apply	\$80/prescription; <u>deductible</u> does not apply	
	Brand drugs (Non-Preferred)	Retail - Preferred - \$110/prescription Non-Preferred - \$130/prescription Mail - \$330/prescription; <u>deductible</u> does not apply	Retail - Preferred - \$110/prescription Non-Preferred - \$130/prescription Mail - \$330/prescription; <u>deductible</u> does not apply	\$130/prescription; <u>deductible</u> does not apply	
	<u>Specialty drugs</u> (Preferred)	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	\$350/prescription; <u>deductible</u> does not apply	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u> (Non-Preferred)	\$450/prescription; <u>deductible</u> does not apply	\$450/prescription; <u>deductible</u> does not apply	\$450/prescription; <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200/visit plus 20% <u>coinsurance</u>	\$400/visit plus 40% <u>coinsurance</u>	\$500/visit plus 50% <u>coinsurance</u>	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$600/visit plus 20% <u>coinsurance</u>	\$600/visit plus 20% <u>coinsurance</u>	\$600/visit plus 20% <u>coinsurance</u>	Per occurrence <u>copayment</u> waived upon inpatient admission.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250/visit plus 20% <u>coinsurance</u>	\$500/visit plus 40% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$1,000 or 50% of the eligible charge In-Network, \$500 Out-of-Network. See your benefit booklet* for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$55/office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	\$75/office visit; <u>deductible</u> does not apply 40% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* for details.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	\$250/visit plus 20% <u>coinsurance</u>	\$500/visit plus 40% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	Primary Care: \$55/initial visit Specialist: \$80/initial visit; <u>deductible</u> does not apply	Primary Care: \$75/initial visit Specialist: \$120/initial visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250/visit plus 20% <u>coinsurance</u>	\$500/visit plus 40% <u>coinsurance</u>	\$600/visit plus 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available; <u>deductible</u> does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available; <u>deductible</u> does not apply	One pair of glasses per year up to age 19. Reimbursement for frames, lenses and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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 25 visits per calendar year)
- Cosmetic surgery (only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (1 per ear every 24 months)
- Infertility treatment (covered for 4 procedures per benefit period)
- Private-duty nursing (with the exception of inpatient private-duty nursing)
- Routine foot care (when medically necessary)

**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 1-800-541-2768 or [www.bcbsil.com](http://www.bcbsil.com), U.S. 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 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 at 1-800-541-2768 or visit [www.bcbsil.com](http://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](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 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 1-800-541-2768.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-541-2768.

*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** \$5,350
- **Specialist copayment** \$80
- **Hospital (facility) copay/coins** \$250+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>	
<u>Deductibles</u>	\$5,350
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,110</b>

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

- **The plan's overall deductible** \$5,350
- **Specialist copayment** \$80
- **Hospital (facility) copay/coins** \$250+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>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

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

- **The plan's overall deductible** \$5,350
- **Specialist copayment** \$80
- **Hospital (facility) copay/coins** \$250+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>	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>





**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., 35<sup>th</sup> 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 مجاناً، 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 કોલ 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 dinit's'á'góó, shá ata' hodooni níningo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jí' hodiilni.
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.

