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, www.myblueelementil.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 https://www.healthcare.gov/sbc-glossary or call 1-855-760-3135 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Duly Provider: $2,500 Individual / $5,000 Family per calendar year. BCBS Preferred Provider[1]: $2,500 Individual / $5,000 Family per calendar year. BCBS Nonpreferred Provider: $6,000 Individual / $12,000 Family per calendar year.	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. Prescription drugs, and the following services by a Duly Provider and/or BCBS Preferred Provider: Preventive care 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?	Duly Provider: $2,500 Individual / $5,000 Family per calendar year. BCBS Preferred Provider[1]: $6,550 Individual / $13,100 Family per calendar year. BCBS Nonpreferred Provider: $15,000 Individual / $20,000 Family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. For services at Duly, the out-of-pocket limit is reached once the deductible is reached; there is no additional cost to the member. For services at non-Duly providers, each family member is capped at the individual out-of-pocket amount, and the total family is capped at the family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. Additionally, certain specialty prescription drugs are considered non-essential health benefits and the cost for them will not be applied towards satisfying your out-of-pocket limits.	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. See www.myblueelementil.com or call 1-855-760-3135 for a list of network providers.	You pay the least if you visit a Duly Provider. You pay more if you use a BCBS Preferred Provider[1]. You will pay the most if you use a BCBS Nonpreferred 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 Duly Provider or BCBS Preferred Provider[1] might use a Nonpreferred 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
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred 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	0% coinsurance	20% coinsurance	40% coinsurance	None.
	Specialist visit	0% coinsurance	20% coinsurance	40% coinsurance	Chiropractic care limited to 20 visits per benefit period. Benefits for acupuncture care is limited to $500 per year.
	Preventive care/screening/ immunization	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply	40% coinsurance	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)	0% coinsurance	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.

[1]BlueCross BlueShield of Illinois' national network includes access to providers across the country.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	Express Scripts Preferred Provider[1] (You will pay more)	Express Scripts Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Retail: 0% coinsurance Mail order: Not Applicable	Retail: 20% coinsurance Mail order: 20% coinsurance	Retail: Not covered Mail order: Not covered	Deductible applies. Duly and In-Network prescription drugs require meeting the In-Network deductible. Preventive drugs covered before the deductible are subject to Rx cost-share provisions. For a full list of these prescriptions, please contact Express Scripts. Coinsurance applies to a 30-day supply Retail and 90-day supply for Mail-Order prescription. Copayment does not apply to preventive drugs required by the Affordable Care Act. Specialty drugs must be obtained by Accredo Specialty Pharmacy or Duly Pharmacy. Full coverage provided for generic and preferred brand diabetic medications and related supplies, and for certain women's preventive services. Prior authorization may be required.
	Preferred brand drugs	Retail: 0% coinsurance Mail order: Not Applicable	Retail: 20% coinsurance Mail order: 20% coinsurance	Retail: Not covered Mail order: Not covered	
	Non-preferred brand drugs	Retail: 0% coinsurance Mail order: Not Applicable	Retail: 20% coinsurance Mail order: 20% coinsurance	Retail: Not covered Mail order: Not covered	
	Specialty drugs	Retail: 0% coinsurance Mail order: Not Applicable	Retail: 20% coinsurance Mail order: 20% coinsurance	Retail: Not covered Mail order: Not covered	

[1]Quincy Medical Group team members pay 10% coinsurance after deductible for prescription drugs received from a participating Express Scripts pharmacy.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	Not applicable	10% coinsurance	Preferred Provider benefit applies	Non-emergency use of the emergency room is not covered. There are no facilities owned and administered by Duly.
	Emergency medical transportation	Not applicable	10% coinsurance	Preferred Provider benefit applies	There is no emergency medical transportation service owned and administered by Duly.
	Urgent care	0% coinsurance	20% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no in-patient facilities owned and administered by Duly.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	40% coinsurance	None.
	Inpatient services	Not applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are inpatient no facilities owned and administered by Duly.

[1] BlueCross BlueShield of Illinois' national network includes access to providers across the country.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	40% coinsurance	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). There are no inpatient facilities owned and administered Duly. Preauthorization is required for high risk maternity. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not applicable	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not applicable	20% coinsurance	40% coinsurance	Home health care visits limited to 60 visits per benefit period. Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no home health care providers owned and administered by Duly.
	Rehabilitation services	0% coinsurance	20% coinsurance	40% coinsurance	Physical and occupational therapy combined limited to 60 visits per benefit period. Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Speech Therapy from Duly and BCBS Preferred Providers will be provided at no charge after Duly deductible.
	Habilitation services	0% coinsurance	20% coinsurance	40% coinsurance	None.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
	Skilled nursing care	Not applicable	20% coinsurance	40% coinsurance	Skilled nursing care limited to 60 days per benefit period. Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no skilled nursing care providers owned and administered by Duly.
	Durable medical equipment	0% coinsurance	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Preauthorization may be required when visiting a non-Duly provider. Failure to obtain prior authorization may result in penalty or increased out-of-pocket costs.
	Hospice services	0% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

[1] BlueCross BlueShield of Illinois' national network includes access to providers across the country.

* For more information about limitations and exceptions, see the plan or policy document at www.myblueelementil.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	• Non-emergency care when traveling outside the U.S.	• Routine foot care (with the exception of persons with diagnosis of diabetes)
• Dental care (Adult and Children)	• Private-duty nursing	• Weight loss programs
• Long-term care	• Routine eye care (Adult and Children)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (max: $500 per member)	• Chiropractic care (max: 20 visits per benefit period)	• Infertility treatment
• Bariatric surgery (max: 1 per lifetime)	• Hearing aids (max: $2,500 per benefit period)	• Speech Therapy

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-855-760-3135.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-760-3135.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-760-3135.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-760-3135.

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

[1] BlueCross BlueShield of Illinois' national network includes access to providers across the country.

* For more information about limitations and exceptions, see the plan or policy document at www.myblueelementil.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 Tier 1 Domestic/Preferred Provider) deductible	$2,500
■ Specialist (Duly) coinsurance	0%
■ Hospital (Preferred Provider 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	$2,500
Copayments (Duly providers)	$0
Coinsurance	$2,040
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,540**

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

■ The plan's overall Tier 1 Domestic/Preferred Provider) deductible	$2,500
■ Specialist (Duly) coinsurance	0%
■ Hospital (Preferred Provider 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	$800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

■ The plan's overall Tier 1 Domestic/Preferred Provider) deductible	$2,500
■ Specialist (Duly) coinsurance	0%
■ Hospital (Preferred Provider facility) coinsurance	20%
■ Emergency Room coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,560**