




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 1-888-802-8776, refer to group number 7BMS92 when calling or visit us at [www.bcbsil.com/boeing](http://www.bcbsil.com/boeing). 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 1-866-473-2016 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$200 per individual.	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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Deductible</a> does not apply to prescription drugs or <a href="#">preventive care</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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,200 per individual, \$9,600 per family for medical expenses; <a href="#">Plan</a> year <a href="#">deductible</a> is not included in out-of-pocket maximum.	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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , balance-billed charges, health care this <a href="#">plan</a> doesn't cover, penalties for failing to obtain <a href="#">preauthorization</a> , <a href="#">deductibles</a> , prescription drugs	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Not Applicable.	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 (You will pay the least)	Nonnetwork (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% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Specialist</a> visit	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Preventive care/screening</a> /immunization	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	According to prescribed guidelines. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	Imaging (CT/PET scans, MRIs)	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
<p><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.myprime.com/boeing">www.myprime.com/boeing</a>.</p>	Generic drugs	Retail: \$5 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply Mail Order: \$10 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply	Retail: Not covered except for emergency Mail Order: Not covered	Retail: 31 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a> Mail Order: 90 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a>
	Preferred brand drugs	Retail: 20%, <a href="#">deductible</a> does not apply, member pays minimum \$10, maximum \$75 per prescription Mail Order: \$30 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply	Retail: Not covered except for emergency Mail Order: Not covered	Retail: 31 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a> Mail Order: 90 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a>
	Non-preferred brand drugs	Retail: 30%, <a href="#">deductible</a> does not apply, member pays minimum \$30, maximum \$100 per prescription Mail Order: \$60 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply	Retail: Not covered except for emergency Mail Order: Not covered	Retail: 31 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a> Mail Order: 90 day supply, does not apply towards your annual <a href="#">out-of-pocket limit</a>
	<a href="#">Specialty drugs</a>	Covered as any other drug	Not covered	You may need to obtain <a href="#">specialty drugs</a> from a pharmacy designated by the service representative

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	Physician/surgeon fees	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Emergency medical transportation</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Urgent care</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	Physician/surgeon fee	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	Inpatient services	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
<b>If you are pregnant</b>	Office visits	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery facility services	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), depending on the type of services, <a href="#">coinsurance</a> may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network (You will pay the least)	Nonnetwork (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Rehabilitation services</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Habilitation services</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Habilitative services not meeting medical necessity/policy are excluded under the <a href="#">plan</a>
	<a href="#">Skilled nursing care</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility, 100 days limited per year, limit does not apply to mental health or substance use disorders
	<a href="#">Durable medical equipment</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
	<a href="#">Hospice services</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	Based on Medicare's determination of patient responsibility
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	————— <a href="#">none</a> —————
	Children's glasses	Covered only for post-cataract surgery	Covered only for post-cataract surgery	Based on Medicare's determination of patient responsibility
	Children's dental check-up	Not covered	Not covered	Not covered under the medical <a href="#">plan</a>

## 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](#).)

- Children's dental check-up
- Children's eye exam
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Hearing aids
- Infertility treatment (limited coverage may apply)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (limited coverage may apply)
- Weight loss programs (unless medically necessary)

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

- Acupuncture
- Bariatric Surgery (limited coverage may apply)
- Chiropractic care
- Non-emergency care when traveling outside the U.S. (limited to what Medicare covers); [www.bcbsil.com/boeing/find-a-doctor-or-hospital/international-travel.html](http://www.bcbsil.com/boeing/find-a-doctor-or-hospital/international-travel.html)

**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: 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act). 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: 1-888-802-8776. You can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act).

**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 1-866-473-2016.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-473-2016.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-473-2016.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-473-2016.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,770</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$800
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$710</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.