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 7IM120 when calling or visit us at 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 or call 1-866-473-2016 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0; Nonnetwork: $450 per individual, $1,350 per 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. Deductible does not apply to network care, copayments and vision.	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?	Network: $2,000 per individual, $4,500 per family for medical and prescription drug expenses; Nonnetwork: $2,450 per individual, $5,850 per family for medical expenses; Nonnetwork applies toward network out-of-pocket maximum, plan year nonnetwork medical deductible is included in out-of-pocket maximum.	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?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to obtain preauthorization, vision.	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.bcbsil.com/boeing or call 1-888-802-8776 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 a nonnetwork 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 a nonnetwork 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
		Network (You will pay the least)	Nonnetwork (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	$30 copayment per visit, deductible not applicable	40% after deductible	——————none——————
	Specialist visit	$40 copayment per visit, deductible not applicable	40% after deductible	——————none——————
	Preventive care/screening/immunization	No charge, deductible not applicable	Not covered	According to prescribed guidelines. 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%, deductible not applicable	40% after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	10%, deductible not applicable	40% after deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myprime.com/boeing.	Generic drugs	Retail: $5 copayment per prescription, deductible not applicable Mail Order: $10 copayment per prescription, deductible not applicable	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies Mail Order: 90 day supply

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)	
	Preferred brand drugs	Retail: $25 copayment per prescription, deductible not applicable Mail Order: $60 copayment per prescription, deductible not applicable	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies, Member Pays the Difference for brand drugs when generic available Mail Order: 90 day supply, Member Pays the Difference for brand drugs when generic available
	Non-preferred brand drugs	Retail: $40 copayment per prescription, deductible not applicable Mail Order: $100 copayment per prescription, deductible not applicable	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies, Member Pays the Difference for brand drugs when generic available Mail Order: 90 day supply, Member Pays the Difference for brand drugs when generic available
	Specialty drugs	Specialty medicines are covered to treat chronic, complex or rare conditions	Not covered	Must be obtained from Specialty Pharmacy, prior authorization or other supply and quantity limits may apply, failure to follow plan procedures may result in non-payment by the plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%, deductible not applicable	40% after deductible	————————none————————
	Physician/surgeon fees	10%, deductible not applicable	40% after deductible	When surgery performed in an outpatient facility
If you need immediate medical attention	Emergency room care	$75 copayment per visit, non-emergent care 40% after copayment, deductible not applicable	$75 copayment per visit, non-emergent care 40% after copayment, deductible does not apply	Copayment waived if admitted
	Emergency medical transportation	10%, deductible not applicable	10%, deductible does not apply	————————none————————

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)	
	Urgent care	$30 copayment per visit, deductible not applicable	40% after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10%, deductible not applicable	40% after deductible	——————none——————
	Physician/surgeon fee	10%, deductible not applicable	40% after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment per office visit, 10% for all other services, deductible not applicable	40% after deductible	Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the plan
	Inpatient services	10%, deductible not applicable	40% after deductible	Failure to obtain preadmission review or preapproval may result in non-payment by the plan
If you are pregnant	Office visits	$30 copayment per visit, unless billed globally, deductible not applicable	40% after deductible	Cost sharing does not apply for preventive services, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10%, deductible not applicable	40% after deductible	Cost sharing does not apply for preventive services, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a copayment, coinsurance, or deductible 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)	
	Childbirth/delivery facility services	10%, deductible not applicable	40% after deductible	Cost sharing does not apply for preventive services, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a copayment, coinsurance, or deductible may apply.
If you need help recovering or have other special health needs	Home health care	10%, deductible not applicable	40% after deductible	130 visits per year, failure to obtain preadmission review or preapproval may result in non-payment or penalty by the plan, visit limit does not apply to mental health and substance use disorders
	Rehabilitation services	10%, $40 copayment per visit for outpatient, deductible not applicable	40% after deductible	——————none——————
	Habilitation services	10%, $40 copayment per visit for outpatient, deductible not applicable	40% after deductible	Habilitative services not meeting medical necessity/policy are excluded under the plan
	Skilled nursing care	10%, deductible not applicable	40% after deductible	Failure to obtain preadmission review or preapproval may result in non-payment by the plan
	Durable medical equipment	20%, deductible not applicable	40% after deductible	——————none——————
	Hospice services	10%, deductible not applicable	40% after deductible	Inpatient limited to 14 days per 6 month period, subject to 6 month review, failure to obtain preadmission review or preapproval may result in non-payment or penalty by the plan
If your child needs dental or eye care	Children's eye exam	Coverage offered through separate vision benefit	Coverage offered through separate vision benefit	Not covered under the medical plan, coverage offered through separate vision benefit

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)	
	Children's glasses	Coverage offered through separate vision benefit	Coverage offered through separate vision benefit	Not covered under the medical plan, coverage offered through separate vision benefit
	Children's dental check-up	Coverage offered through separate dental benefit	Coverage offered through separate dental benefit	Not covered under the medical plan, coverage offered through separate dental benefit

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.)

- Bariatric surgery
- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Infertility treatment (limited coverage may apply)
- Long-term care
- Private-duty nursing (limited coverage may apply)
- Routine eye care (Adult)
- Routine foot care (limited coverage may 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
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.; https://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. 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: 1-888-802-8776. You can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-473-2016.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-473-2016.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-473-2016.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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 plan's overall deductible	$0
Specialist copayment	$40
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	$0
Copayments	$10
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,370**

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

The plan's overall deductible	$0
Specialist copayment	$40
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	$0
Copayments	$900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$930**

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

The plan's overall deductible	$0
Specialist copayment	$40
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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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