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

: G506OPT Blue Options Gold PPO℠ 101

Coverage Period: 01/01/2024-12/31/2024

Coverage for: Individual + Family | Plan Type: PPO

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_gpsg12bcosilo_il_2024.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/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Blue Choice $750; PPO $2,000; Out-of-Network $4,000 Family: Blue Choice $2,250; PPO $6,000; Out-of-Network $12,000	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. In-Network Preventive Health Care services, some services with a copayment, and prescription drugs 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 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?	Individual: Blue Choice $6,750; PPO $8,500; Out-of-Network Unlimited Family: Blue Choice $17,300; PPO $18,200; Out-of-Network Unlimited	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 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/blueoptions or call 1-800-541-2768 for a list of Participating Providers.	You pay the least if you use a provider in Blue Choice. You pay more if you use a provider in PPO Provider. 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).
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
		Blue Choice Provider (You will pay the least)	PPO 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	$40/visit; deductible does not apply	$60/visit; deductible does not apply	50% coinsurance	Virtual Visits: $40/visit. See your benefit booklet* for details.
	Specialist visit	$60/visit; deductible does not apply	$100/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% 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)	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/grp/bb_gpsg12bcosilo_il_2024.pdf

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com/rx24/6T	Generic drugs (Preferred)	Retail - Preferred - $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	Retail - Preferred - $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	$20/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs 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 deductible or out-of-pocket maximum. The applicable cost sharing (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 copayment/coinsurance. Additional charge will not apply to any deductible 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.
	Generic drugs (Non-Preferred)	Retail - Preferred - $20/prescription Non-Preferred - $30/prescription Mail - $60/prescription; deductible does not apply	Retail - Preferred - $20/prescription Non-Preferred - $30/prescription Mail - $60/prescription; deductible does not apply	$30/prescription; deductible does not apply	
	Brand drugs (Preferred)	Retail - Preferred - $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	Retail - Preferred - $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	$70/prescription; deductible does not apply	
	Brand drugs (Non-Preferred)	Retail - Preferred - $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	Retail - Preferred - $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	$120/prescription; deductible does not apply	
	Specialty drugs (Preferred)	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	

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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)	
	Specialty drugs (Non-Preferred)	$350/prescription; deductible does not apply	$350/prescription; deductible does not apply	$350/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200/visit plus 20% coinsurance	$400/visit plus 40% coinsurance	$500/visit plus 50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$600/visit plus 20% coinsurance	$600/visit plus 20% coinsurance	$600/visit plus 20% coinsurance	Per occurrence copayment waived upon inpatient admission.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	$75/visit; deductible does not apply	$75/visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/visit plus 20% coinsurance	$500/visit plus 40% coinsurance	$600/visit plus 50% coinsurance	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% coinsurance	40% coinsurance	50% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40/office visit; deductible does not apply 20% coinsurance for other outpatient services	$60/office visit; deductible does not apply 40% coinsurance for other outpatient services	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	$250/visit plus 20% coinsurance	$500/visit plus 40% coinsurance	$600/visit plus 50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	Primary Care: $40 Specialist: $60; deductible does not apply	Primary Care: $60 Specialist: $100; deductible does not apply	50% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment,

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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)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	50% coinsurance	coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	$250/visit plus 20% coinsurance	$500/visit plus 40% coinsurance	$600/visit plus 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	50% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	Up to a $30 reimbursement is available; deductible 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; deductible does not apply	No Charge; deductible does not apply	Up to a $75 reimbursement is available; deductible 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% coinsurance	30% coinsurance	50% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/grp/bb_gpsg12bcosilo_il_2024.pdf

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)	• 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 (for children 1 per ear every 24 months, for adults up to $2,500 per ear every 24 months) • Infertility treatment (covered for 4 procedures per benefit period) • Long-term care	• 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, 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 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, 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 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, kwiijigo 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	**$750**
Specialist copayment	**$60**
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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,410**

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

The plan's overall deductible	**$750**
Specialist copayment	**$60**
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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1,200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	**$750**
Specialist copayment	**$60**
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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
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SBC IL Non-HMO SG-2024

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

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Health care coverage is important for everyone.

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.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

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, Illinois 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/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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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.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा म निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक स बात करन क लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.