BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company **: S507OPT Blue Options Silver PPO℠ 107**

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/il/documents/group/benefit-booklets/2026/bb_spsg12bcosilo_il_2026.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 $5,200; PPO $6,000; Out-of-Network $16,500 Family: Blue Choice $15,600; PPO $16,900; Out-of-Network $45,000	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 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 $5,200; PPO $8,000; Out-of-Network Unlimited Family: Blue Choice $15,600; PPO $16,900; 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). Be aware your network provider might use an out-of-network 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
		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	No Charge after deductible	30% coinsurance	50% coinsurance	Virtual Visits: No Charge after deductible. See your benefit booklet* for details.
	Specialist visit	No Charge after deductible	30% coinsurance	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)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	30% 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/il/documents/group/benefit-booklets/2026/bb_spsg12bcosilo_il_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay: Blue Choice Provider (You will pay the least)	What You Will Pay: PPO Provider (You will pay more)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com/rx26/6T	Generic drugs (Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	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 $35, when obtained from a Preferred Participating or Participating Pharmacy.
	Generic drugs (Non-Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	
	Brand drugs (Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	
	Brand drugs (Non-Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	
	Specialty drugs (Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	
	Specialty drugs (Non-Preferred)	No Charge after deductible	No Charge after deductible	No Charge after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	No Charge after deductible	None

Common Medical Event	Services You May Need	What You Will Pay: Blue Choice Provider (You will pay the least)	What You Will Pay: PPO Provider (You will pay more)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	No Charge after deductible	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	No Charge after deductible	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	30% coinsurance	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	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No Charge after deductible	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No Charge after deductible	30% coinsurance	50% coinsurance	
If you need help recovering or have	Home health care	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.

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)	
other special health needs	Rehabilitation services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Habilitation services	No Charge after deductible	30% coinsurance	50% coinsurance	
	Skilled nursing care	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Durable medical equipment	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Hospice services	No Charge after deductible	30% 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 after deductible	No Charge after deductible	Up to a $75 reimbursement is available after deductible	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

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, 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.GetCovered.Illinois.gov or call 1-866-311-1119, TTY 711.

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	**$5,200**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

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	$5,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,260**

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

The plan's overall deductible	**$5,200**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

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	$2,300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	**$5,200**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

BlueCross BlueShield of Illinois

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

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.
To receive reasonable modifications, communication aids or language 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, you can file a grievance with: Office of Civil Rights Coordinator Attn: Office of Civil Rights Coordinator 300 E. Randolph St., 35th Floor Chicago, IL 60601 Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 Email: civilrightscoordinator@bcbsil.com You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).
You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at: US Dept of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201 Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of Illinois

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

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yániłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.