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 7IF760 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?	$1,400 Self Only or $2,800 Self + Family, family level deductible may be met by one or a combination of members. Network-Nonnetwork combined.	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. Deductible does not apply to copayments, preventive care or 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: $3,100 Self Only or $6,200 Self + Family for medical and prescription drug expenses; Nonnetwork: $4,800 Self Only or $9,600 Self + Family for medical and prescription drug expenses; Family level out-of-pocket maximum may be met by one or a combination of members, plan year 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, the overall family out-of-pocket limit must be 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	10% after deductible	40% after deductible	——————none——————
	Specialist visit	10% after deductible	40% after deductible	——————none——————
	Preventive care/screening/immunization	No charge, deductible does not apply	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% after deductible	40% after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	10% after deductible	40% after deductible	——————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)	
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: 10% after deductible Mail Order: 10% after deductible	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies, certain preventive drugs not subject to deductible Mail Order: 90 day supply, certain preventive drugs not subject to deductible
	Preferred brand drugs	Retail: 25% after deductible Mail Order: 25% after deductible	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies, certain preventive drugs not subject to deductible, Member Pays the Difference for brand drugs when generic available Mail Order: 90 day supply, certain preventive drugs not subject to deductible, Member Pays the Difference for brand drugs when generic available
	Non-preferred brand drugs	Retail: 35% after deductible Mail Order: 35% after deductible	Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies, certain preventive drugs not subject to deductible, Member Pays the Difference for brand drugs when generic available Mail Order: 90 day supply, certain preventive drugs not subject to deductible, Member Pays the Difference for brand drugs when generic available
	Specialty drugs	Specialty drug programs apply for certain high cost items	Not covered	Preauthorization may apply or you may need to obtain specialty drugs from a pharmacy designated by the service representative, 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% after deductible	40% after deductible	——————none——————
	Physician/surgeon fees	10% after deductible	40% after deductible	——————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)	
If you need immediate medical attention	Emergency room care	10% after deductible, non-emergent care 40% after deductible	10% after deductible, non-emergent care 40% after deductible	——————none——————
	Emergency medical transportation	10% after deductible, non-emergent care 40% after deductible	10% after deductible, non-emergent care 40% after deductible	——————none——————
	Urgent care	10% after deductible	40% after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	40% after deductible	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Physician/surgeon fee	10% after deductible	40% after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after deductible	40% after deductible	Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the plan
	Inpatient services	10% after deductible	40% after deductible	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges

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 are pregnant	Office visits	10% after deductible	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 coinsurance or deductible may apply.
	Childbirth/delivery professional services	10% after deductible	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 coinsurance or deductible may apply.
	Childbirth/delivery facility services	10% after deductible	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 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)	
If you need help recovering or have other special health needs	Home health care	10% after deductible	40% after deductible	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Rehabilitation services	10% after deductible	40% after deductible	After 30 visits per therapy per year, continued therapy must be approved by the service representative
	Habilitation services	10% after deductible	40% after deductible	Habilitative services not meeting medical necessity/policy are excluded under the plan
	Skilled nursing care	10% after deductible	40% after deductible	Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
	Durable medical equipment	10% after deductible	40% after deductible	————none————
	Hospice services	10% after deductible	10% after deductible	Subject to 6 month review, preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges
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
	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.)

- 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
- Bariatric surgery (limited coverage may apply)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.; 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 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, kwiijigo 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 plan's overall deductible	$1400
Specialist coinsurance	10%
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	$1,400
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$1400
Specialist coinsurance	10%
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	$1,400
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	$1400
Specialist coinsurance	10%
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	$1,400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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