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 7IM101 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: $400 per individual, $1,200 per family; Nonnetwork: $800 per individual, $2,400 per family. Nonnetwork charges will apply to network.	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 copayments, prescription drugs, 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?	Yes, applies to prescription drugs. Network: $75 per individual, $225 per family, applies to retail only, Nonnetwork: $75 per individual, $225 per family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,000 per individual, $4,500 per family for medical expenses; Network-Nonnetwork combined, plan year medical deductible is not included in medical out-of-pocket maximum amount; Separate $6,075 per individual, $11,175 per family for network prescription drug expenses	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, medical and prescription drug deductibles	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 does not apply	40% after deductible	Annual deductible does not apply to network provider office visits; any lab, x-ray or other services performed during the visit are subject to the annual deductible
	Specialist visit	$40 copayment per visit, deductible does not apply	40% after deductible	Annual deductible does not apply to network provider office visits; any lab, x-ray or other services performed during the visit are subject to the annual deductible
	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: $5 copayment per prescription after prescription drug deductible Mail Order: $10 copayment per prescription, deductible does not apply	Retail: $5 copayment per prescription after prescription drug deductible Mail Order: Not covered	Retail: 30 day supply, up to 90 days available at many retail pharmacies Mail Order: 90 day supply
	Preferred brand drugs	Retail: $25 copayment per prescription after prescription drug deductible Mail Order: $60 copayment per prescription, deductible does not apply	Retail: $25 copayment per prescription after prescription drug deductible Mail Order: 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 after prescription drug deductible Mail Order: $100 copayment per prescription, deductible does not apply	Retail: $40 copayment per prescription after prescription drug deductible Mail Order: 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	Covered as any other drug	Covered as any other drug	You may need to obtain specialty drugs from a pharmacy designated by the service representative
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	$75 copayment per visit, then 10% after deductible	$75 copayment per visit, then 10% after deductible, non-emergent care 40% after deductible and copayment	Copayment waived if admitted
	Emergency medical transportation	10% after deductible	10% after deductible	——————none——————
	Urgent care	$30 copayment per visit, deductible does not apply	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	No charge, deductible does not apply	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	$30 copayment per visit, deductible does not apply	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% 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 copayment, 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 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)	
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 3 months, 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	10% 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	Not covered	Not covered	——————none——————
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan

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	$400
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*	$400
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

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

The plan's overall deductible	$400
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*	$200
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	$400
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*	$400
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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