




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 7NUS00 when calling or visit us at [www.bcbsil.com/boeing](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-866-473-2016 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network</a> : \$500 per individual, \$1,500 per family; Nonnetwork: \$1,000 per individual, \$3,000 per family. Nonnetwork charges apply toward the <a href="#">network deductible</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Deductible</a> does not apply to <a href="#">copayments</a> , <a href="#">prescription drugs</a> , <a href="#">preventive care</a> or vision.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network</a> : \$2,200 per individual, \$6,600 per family for medical expenses; Nonnetwork: \$4,400 per individual, \$13,200 per family for medical expenses; Nonnetwork applies toward <a href="#">network</a> medical out-of-pocket maximum, <a href="#">plan</a> year medical <a href="#">deductible</a> is included in medical out-of-pocket maximum amount; Separate \$5,150 per individual, \$8,100 per family for <a href="#">network</a> prescription drug expenses.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance-billed charges, health care this <a href="#">plan</a> doesn't cover, penalties for failing to obtain <a href="#">preauthorization</a> , vision.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com/boeing">www.bcbsil.com/boeing</a> or call 1-888-802-8776 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">nonnetwork provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use a <a href="#">nonnetwork provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
	<a href="#">Specialist</a> visit	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
	<a href="#">Preventive care/screening</a> /immunization	No charge, <a href="#">deductible</a> does not apply	Not covered	According to prescribed guidelines. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————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)	
<p><b>If you need drugs to treat your illness or condition</b>            More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myprime.com/boeing">www.myprime.com/boeing</a>.</p>	Generic drugs	Retail: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$10, maximum \$50 per prescription Mail Order: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$25, maximum \$130 per prescription	Retail: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$10, maximum \$50 per prescription 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%, <a href="#">deductible</a> does not apply, member pays minimum \$35, maximum \$125 per prescription Mail Order: 25%, <a href="#">deductible</a> does not apply, member pays minimum \$85, maximum \$310 per prescription	Retail: 25%, <a href="#">deductible</a> does not apply, member pays minimum \$35, maximum \$125 per prescription 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: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$50 (no maximum) per prescription Mail Order: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$125 (no maximum) per prescription	Retail: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$50 (no maximum) per prescription 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

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)	
	<a href="#">Specialty drugs</a>	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 <a href="#">plan</a> procedures may result in non-payment by the <a href="#">plan</a>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
	Physician/surgeon fees	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	When surgery performed in an outpatient facility
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a> per visit, then no charge after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a> and <a href="#">copayment</a>	\$100 <a href="#">copayment</a> per visit, then no charge after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a> and <a href="#">copayment</a>	<a href="#">Copayment</a> waived if admitted
	<a href="#">Emergency medical transportation</a>	10% after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a>	10% after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a>	—————none—————
	<a href="#">Urgent care</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges
	Physician/surgeon fee	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the <a href="#">plan</a>
	Inpatient services	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	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 <a href="#">deductible</a>	40% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges
	<a href="#">Rehabilitation services</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	After 30 visits per therapy per year, continued therapy must be approved by the service representative
	<a href="#">Habilitation services</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	Habilitative services not meeting medical necessity/policy are excluded under the <a href="#">plan</a>
	<a href="#">Skilled nursing care</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	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)	
	<a href="#">Durable medical equipment</a>	10% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	—————none—————
	<a href="#">Hospice services</a>	10% after <a href="#">deductible</a>	10% after <a href="#">deductible</a>	Subject to 6 month review, preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges
<b>If your child needs dental or eye care</b>	Children's eye exam	Coverage offered through separate vision benefit	Coverage offered through separate vision benefit	Not covered under the medical <a href="#">plan</a> , 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 <a href="#">plan</a> , 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 <a href="#">plan</a> , 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)
- 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
- Infertility treatment (limited coverage may apply)
- 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](http://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](http://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): 如果需要中文的帮助, 请拨打这个号码 1-866-473-2016.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-473-2016.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,760</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.