



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

New Albertsons, L. P.: Enhanced BlueAdvantage HMO Plan

Coverage for: Individual / Family | Plan Type: HMO




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 1-800-892-2803 or at

<https://policy-srv.box.com/s/veiwm8a9vw0nvfojuonwbme0ofv5jchp>.

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?	\$100 Individual / \$300 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> and services that charge a <u>copayment</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$3,000 Individual / \$6,000 Family Prescription drug limit: \$3,600 Individual/\$7,200 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-892-2803 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		In-Network Provider (You will pay the least)	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	\$50/visit; <u>deductible</u> does not apply	Not Covered	Services or supplies that are not ordered by your <u>Primary Care Physician</u> or Women's Principal Health Care <u>Provider</u> , except emergency and routine vision exams, are not covered.
	<u>Specialist</u> visit	\$60/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called BCBSIL)

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*For more information about limitations and exceptions, see the plan or policy document at

<https://policy-srv.box.com/s/veiw8a9vw0nvfojuonwbme0ofv5jchp>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	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.medimpact.com or 1-888-402-1984	Generic drugs	20% coinsurance (\$4 minimum/\$20 maximum copay) retail 30-day 20% coinsurance (\$8 minimum/\$40 maximum copay) retail 31-60 day 20% coinsurance (\$12 minimum/\$60 maximum copay) retail/mail order-90 day	Not Covered	Retail-covers up to a 30-day supply Retail-covers 31-60 days supply Retail or Mail Order-covers up to a 90-day supply Out-of-Pocket Limit Individual: \$3,600 Family: \$7,200
	Preferred brand drugs	30% coinsurance (\$40 minimum/\$100 maximum copay) retail 30-day 30% coinsurance (\$80 minimum/\$200 maximum copay) retail 31-60 day 30% coinsurance (\$100 minimum/\$250 maximum copay) retail/mail order-90 day	Not Covered	
	Non-preferred brand drugs	50% coinsurance (\$70 minimum/\$160 maximum copay) retail 30-day 50% coinsurance (\$140 minimum/\$320 maximum copay) retail 31-60 day 50% coinsurance (\$175 minimum/\$380 maximum copay) retail/mail order-90 day	Not Covered	
	<u>Specialty drugs</u>	Covered as listed above	Covered as listed above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. \$500 participating outpatient surgery per occurrence <u>copayment</u> .
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$300/visit plus 10% <u>coinsurance</u> ER Physician Charges: 10% <u>coinsurance</u>	Facility Charges: \$300/visit plus 10% <u>coinsurance</u> ER Physician Charges: 10% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Ground transportation only.
	<u>Urgent Care</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	Must be affiliated with member's chosen medical group or <u>referral</u> required.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. \$750 <u>copayment</u> for the 1st 3 days per calendar year.
	Physician/surgeon fees	No Charge	Not Covered	<u>Referral</u> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50/visit; <u>deductible</u> does not apply	Not Covered	Unlimited visits. <u>Referral</u> required.
	Inpatient services	10% <u>coinsurance</u>	Not Covered	Unlimited days. <u>Referral</u> required. \$750 <u>copayment</u> for the 1st 3 days per calendar year.
If you are pregnant	Office visits	\$50 PCP/\$60 SPC/visit; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies for the 1st prenatal visit only. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>deductible</u> may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. \$750 <u>copayment</u> for the 1st 3 days per calendar year.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	<u>Rehabilitation services</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	60 visits combined for all therapies. <u>Referral</u> required.
	<u>Habilitation services</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	Excludes custodial care. <u>Referral</u> required. \$750 <u>copayment</u> for the 1st 3 days per calendar year
	<u>Durable medical equipment</u>	No Charge	Not Covered	<u>Referral</u> required. Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	No Charge	Not Covered	Inpatient <u>copayment</u> may apply. <u>Deductible</u> does apply. <u>Referral</u> required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating <u>providers</u> .
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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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.)

- Custodial care
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (only for correcting 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 (4 invitro attempt maximum with special approval up to 6 per benefit period)
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Routine foot care (only in connection with diabetes)
- Weight loss programs (except when non-medically supervised)

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: For group health coverage contact the plan Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com. For group health coverage subject to ERISA contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 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 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-2803.

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** **\$100**
- **Specialist copayment** **\$60**
- **Hospital (facility) both** **\$750+10%**
- **Other copayment** **\$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
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In this example, Peg would pay:

<i>Cost sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$900

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$1,860
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Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **\$100**
- **Specialist copayment** **\$60**
- **Hospital (facility) both** **\$750+10%**
- **Other copayment** **\$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
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In this example, Joe would pay:

<i>Cost sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$1,000

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$1,620
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Mia's Simple Fracture

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

- **The plan's overall deductible** **\$100**
- **Specialist copayment** **\$60**
- **Hospital (facility) both** **\$750+10%**
- **Other copayment** **\$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
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In this example, Mia would pay:

<i>Cost sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$100

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$900
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The plan would be responsible for the other costs of these EXAMPLE covered services.

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BlueCross BlueShield of Illinois

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Health care coverage is important for everyone.

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. 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. 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, IL 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/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jil' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.