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 1-800-828-3116 or at https://policy-srv.box.com/s/9ov1pd8b5juvyddwtv0cvtez5fcwkhx4.

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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $1,000 Individual/$2,000 Family For Out-of-Network: $2,000 Individual/$4,000 Family	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. Certain preventive care, services that charge a copay, prescription drugs and emergency room 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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 deductible for Out-of-Network hospital admission. 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?	For In-Network: $3,500 Individual/$7,000 Family For Out-of-Network: $7,000 Individual/$14,000 Family	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, balanced-billed charges, and healthcare 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 or call 1-800-828-3116 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 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
		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	$40 copay/visit; deductible does not apply	40% coinsurance	No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary. Copay applies to the office visit and all other services provided in office on same day, except for surgery, mental health, emergency care, physical, occupational and speech therapies or chiropractic manipulation.
	Specialist visit	$60 copay/visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% 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)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/9ov1pd8b5juvyddwtv0cvtez5fcwkhx4.

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.bcbsil.com.	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order) deductible does not apply	$10 copay/prescription (retail) deductible does not apply	34-day supply at Retail 90-day supply at Mail Order For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the copayment. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order) deductible does not apply	$40 copay/prescription (retail) deductible does not apply	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order) deductible does not apply	$60 copay/prescription (retail) deductible does not apply	
	Specialty drugs	$60 copay/prescription (retail) deductible does not apply	$60 copay/prescription (retail) deductible does not apply	Coverage based on group policy. Specialty retail limited to 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay/visit; deductible does not apply plus 20% coinsurance	$200 copay/visit; deductible does not apply plus 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/9ov1pd8b5juvyddwtv0cvtez5fcwkhx4.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. See your benefit booklet* for details. $300 deductible per admission Out-of-Network providers.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details. PCP copay applies to psychotherapy office visit only.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.
If you are pregnant	Office visits	$40 copay/visit; deductible does not apply	40% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.

* For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/9ov1pd8b5juvyddwtv0cvtez5fcwkhx4.

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	Home health care	20% coinsurance	40% coinsurance	Preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization required.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.
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	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

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

- Chiropractic care (limited to 30 visits)
- Infertility treatment
- Most coverage provided outside the United States. (See www.bcbsil.com)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (with the exception of inpatient private duty nursing)

* For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/9ov1pd8b5juvyddwtv0cvtez5fcwkhx4.

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 1-800-828-3116, 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.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: Blue Cross and Blue Shield of Illinois at 1-800-828-3116 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 (877) 527-9431 or visit http://insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-828-3116.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-828-3116.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-828-3116.

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	$1,000
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

■ The plan's overall deductible	$1,000
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,560**

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

■ The plan's overall deductible	$1,000
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,470**

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