This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **(888) 619-5364 or (972) 943-9559.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000/person; $3,000/family. Charges incurred last 3 months of year also apply to next year. Deductibles do not apply to prescription drugs, balance billing, excluded services or penalties.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. $200/person non-PPO inpatient hospital deductible (up to $400/person); Prescription drugs: $50/person. 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.
Is there an out–of–pocket limit on my expenses?	Yes. PPO: $5,850/person; $11,700/family. Prescription drugs: $1,000/person; $2,000 family. Includes prescription drug deductibles & coinsurance. Charges incurred last 3 months of year also apply to next year. Non-PPO: no out-of-pocket limit (you are responsible for all amounts over plan's percentage of allowed amount).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan does not cover, penalties, charges in excess of reasonable & customary, charges subject to coordination of benefits & charges paid at 100%	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of PPO providers, go to www.BCBSIL.com or call (800) 810-2583	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	You are responsible for Non-PPO expenses above the PPO allowed amount.
	Specialist visit	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
	Other practitioner office visit	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Chiropractic limited to 20 visits/year up to a maximum of $1,500/year
	Preventive care/screening/ immunization	No charge	Routine physicals: 90% coinsurance. Well child care: no charge up to $400, then 50% coinsurance. No cost for certain immunizations, mammograms, pap tests & prostate exams.	PPO providers: covered services based on Affordable Care Act requirements. Frequency & age limits apply. Non-PPO providers: certain limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	You are responsible for Non-PPO expenses above the PPO allowed amount.
	Imaging (CT/PET scans, MRIs)	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com	Generic drugs	100% until $50 deductible met; 20% coinsurance until out-of-pocket limit met, then plan pays 100%	Not covered	Deductible & coinsurance amounts count toward in-network out-of-pocket limit.
	Preferred brand drugs	100% until $50 deductible met; 40% coinsurance until out-of-pocket limit met, then plan pays 100%	Not covered	
	Non-preferred brand drugs	100% until $50 deductible met; 40% coinsurance until out-of-pocket limit met, then plan pays 100%	Not covered	
	Specialty drugs	100% until $50 deductible met; 40% coinsurance until out-of-pocket limit met, then plan pays 100%	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	You are responsible for Non-PPO expenses above the PPO allowed amount.
	Physician/surgeon fees	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
If you need immediate medical attention	Emergency room services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 20% coinsurance thereafter	Supplemental accident benefit waives deductible and plan pays 100% up to $250 if within first 90 days after accidental injury. Only local ground ambulance service covered.
	Emergency medical transportation	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
	Urgent care	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	100% until deductible met; 20% coinsurance thereafter (semi-private room). If no semi-private room available, allowed amount is equal to 90% of the lowest daily private room rate.	100% until deductible met; 40% coinsurance thereafter (semi-private room). If no semi-private room available, allowed amount is equal to 90% of the lowest daily private room rate.	Advance precertification required (or within 72 hours after an emergency) or benefits reduced by 50%, up to $500 per stay. Non-emergency hospital stay that begins on Friday, Saturday or Sunday is not covered. You are responsible for Non-PPO expenses above the PPO allowed amount.
	Physician/surgeon fee	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Same benefits & limitations that apply to inpatient hospital stay. You are responsible for Non-PPO expenses above the PPO allowed amount.
	Mental/Behavioral health inpatient services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
	Substance use disorder outpatient services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Same benefits & limitations that apply to inpatient hospital stay. You are responsible for Non-PPO expenses above the PPO allowed amount
	Substance use disorder inpatient services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	
If you are pregnant	Prenatal and postnatal care	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Pregnancy expenses of a dependent child (other than Complications of Pregnancy and certain pregnancy-related preventive care services) are not covered.
	Delivery and all inpatient services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Limited to private duty nursing services from approved providers.
	Rehabilitation services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Limited to 20 visits/year for physical therapy, occupational therapy or a combination of both; In addition, up to 20 visits/year for post-surgery physical therapy.
	Habilitation services	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Limited to 20 visits/year for physical therapy, occupational therapy or a combination of both
	Skilled nursing care	100% until deductible met; 20% coinsurance thereafter (based on 50% of prior hospital's daily semi-private room rate).	100% until deductible met; 40% coinsurance thereafter (based on 50% of prior hospital's daily semi-private room rate).	Must follow hospital stay of 5 or more days and be within 14 days after hospital discharge. Limited to 100 days/confinement and 365 days/lifetime.
	Durable medical equipment	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Predetermination required if cost of equipment is $400 or more.
	Hospice service	20% coinsurance	20% coinsurance	Deductible waived. Must be terminally ill. Lifetime maximum: 30 days room & board, plus fees for miscellaneous hospice care & physician's services. Bereavement counseling covered up to $500. Other limitations apply.
If your child needs dental or eye care	Eye exam	No charge up to $50/exam with additional $30 for dilation; 100% thereafter	No charge up to $50/exam with additional $30 for dilation; 100% thereafter	$750/person maximum (combination of exams, glasses & contact lenses) for a 24-consecutive month period beginning on July 1. Benefits & limitations apply to specific services. Maximum does not apply to pediatric vision care for children up to age 19.
	Glasses	No charge up to $100/single vision lenses and $100/frames; 100% thereafter	No charge up to $100/single vision lenses and $100/frames; 100% thereafter	
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
• Acupuncture	• Cosmetic surgery (exceptions: repair of injury; dependent child's congenital defects; breast reconstruction after mastectomy)	• Charges in excess of Allowed Amount (based on network rates, Reasonable & customary and Medical necessity)	• Custodial care
• Dental care (Adult)	• Dental care (children/dependents)	• Hearing aids	• Infertility treatment
• Intentional self-inflicted injury	• Long-term care	• Non-emergency care when traveling outside the U.S	• Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery (limitations apply)	• Chiropractic care (limitations apply)	• Private-duty nursing (limitations apply)
• Routine eye care (Adult)	• Weight loss programs (limitations apply)	

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (888) 619-5364 or (972) 943-9559. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at (888) 619-5364 or (972) 943-9559. You may also contact the Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al (888) 619-5364 or (972) 943-9559

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **Patient pays** $2,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,020
Copays	$0
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,430
- **Patient pays** $1,970

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,050
Copays	$0
Coinsurance	$840
Limits or exclusions	$80
Total	**$1,970**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.