



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 (888) 619-5364 or (469) 423-6100. 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.healthcare.gov/sbc-glossary> or call (888) 619-5364 or (469) 423-6100 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$800/person; \$2,400/family. Charges incurred last 3 months of year also apply to next year. <u>Deductibles</u> do not apply to <u>prescription drugs</u> , <u>balance billing</u> , excluded services, or penalties.	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?	<u>In-network preventive care</u> as required by the Affordable Care Act. May not exceed the <u>Plan's</u> Reasonable Charge. <u>Deductible</u> does not apply to hospice services.	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 cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$200/person non-PPO inpatient hospital <u>deductible</u> (up to \$400/person); <u>Prescription drugs</u> : \$50/person. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	PPO : \$5,850/person; \$11,700/family. <u>Prescription drugs</u> : \$1,000/person; \$2,000 family. Includes <u>prescription drug deductibles</u> & <u>coinsurance</u> . Charges incurred last 3 months of year also apply to next year. Non-PPO : no <u>out-of-pocket limit</u> (you are responsible for all amounts over <u>plan's</u> percentage of allowed amount).	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 billed charges</u> , health care this <u>plan</u> does not cover, penalties, charges in excess of <u>usual, customary and reasonable</u> , charges subject to coordination of benefits, & charges paid at 100%.	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. For a list of PPO <u>providers</u> , go to www.BCBSIL.com or call (800) 810-2583.	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</u> charge 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?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		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	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter.	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Note: You are responsible for Non-PPO expenses above the PPO <u>allowed amount</u> . No charge for telemedicine (MDLive®). PPO providers: covered services based on Affordable Care Act requirements. Frequency & age limits apply. Non-PPO providers: certain limitations apply. You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive care</u> . Then check what your <u>plan</u> will pay for.
	Specialist visit			
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply	Routine physicals: 90% <u>coinsurance</u> . Well child care: no charge up to \$400, then 50% <u>coinsurance</u> . Certain immunizations, mammograms, pap tests, & prostate exams: no charge.	
If you have a test	Diagnostic test (x-ray, blood work)	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Note: You are responsible for Non-PPO expenses above the PPO <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.savrx.com .	Generic drugs	100% until \$50 <u>deductible</u> met; 20% <u>coinsurance</u> until <u>out-of-pocket limit</u> met; no charge thereafter	Not Covered	<u>Deductible</u> & <u>coinsurance</u> amounts count toward <u>in-network</u> and <u>out-of-pocket limit</u> .
	Preferred brand drugs	100% until \$50 <u>deductible</u> met; 40% <u>coinsurance</u> until <u>out-of-pocket limit</u> met; no charge thereafter		
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	You are responsible for Non-PPO expenses above the PPO <u>allowed amount</u> .
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	Supplemental accident benefit waives <u>deductible</u> and <u>plan</u> pays 100% up to \$250 if within first 90 days after accidental injury. Only local ground ambulance service covered.
	<u>Emergency medical transportation</u>	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	
	<u>Urgent care</u>			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Pre-certification required (or within 72 hours after an emergency admission) or benefits reduced by 50%, up to \$500 per stay. Non-emergency hospital stay that begins on Friday, Saturday or Sunday is not covered. Semi-private room rate applies (if none available, <u>allowed amount</u> equals 90% of lowest daily private room rate). You are responsible for Non-PPO expenses above the PPO <u>allowed amount</u> .
	<u>Physician/surgeon fees</u>			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Same benefits & limitations that apply to inpatient hospital stay. You are responsible for Non-PPO expenses above the PPO <u>allowed amount</u> .
	Inpatient services			
If you are pregnant	Office visits	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Pregnancy expenses of a dependent child (other than <u>Complications of Pregnancy</u> and certain pregnancy-related <u>preventive care services</u>) are not covered. Maternity care may include tests and services described elsewhere in this SBC (i.e., ultrasound). <u>Cost sharing</u> does not apply for <u>preventive care services</u> .
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Limited to private duty nursing services from approved <u>providers</u> .
	<u>Rehabilitation services</u>			Limited to 20 visits/year for physical therapy, occupational therapy, or a combination of both; Plus, up to 20 visits/year for post-surgery physical therapy.
	<u>Habilitation services</u>			Limited to 20 visits/year for physical therapy, occupational therapy, or a combination of both.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	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. Benefit based on 50% of prior hospital's daily semi-private room rate.
	<u>Durable medical equipment</u>	100% until <u>deductible</u> met; 20% <u>coinsurance</u> thereafter	100% until <u>deductible</u> met; 40% <u>coinsurance</u> thereafter	Pre-approval required if cost of equipment is \$400 or more.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Deductible</u> waived. Must be terminally ill. Lifetime maximum: 30 days room & board, plus fees for miscellaneous hospice care & <u>physician's services</u> . Bereavement counseling covered up to \$500. Other limitations apply.
If your child needs dental or eye care More information available at www.GuardianAnytime.com or by calling 877-814-8970.	Children's eye exam	Not covered	Not covered	Vision benefits may be available under a separate plan through Guardian Vision.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not Covered	Not Covered	Dental benefits may be available under a separate plan through Guardian Dental.

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.)			
<ul style="list-style-type: none"> Acupuncture 	<ul style="list-style-type: none"> Cosmetic surgery (exceptions: repair of injury; dependent child's congenital defects; breast reconstruction after mastectomy) 	<ul style="list-style-type: none"> Charges in excess of <u>allowed amount</u> (based on network rates, <u>usual, customary and reasonable</u> and <u>medical necessity</u>) 	<ul style="list-style-type: none"> Custodial Care
<ul style="list-style-type: none"> Dental and eye care (Adult and child) (available under separate plan through Guardian Dental and Vision) 	<ul style="list-style-type: none"> Gene therapy 	<ul style="list-style-type: none"> Hearing aids 	<ul style="list-style-type: none"> Infertility treatment
<ul style="list-style-type: none"> Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine foot care 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric surgery (exceptions may apply) 	<ul style="list-style-type: none"> Chiropractic care (limitations apply) 	<ul style="list-style-type: none"> Cochlear implants (limitations apply)
<ul style="list-style-type: none"> Private-duty nursing (limitations apply) 	<ul style="list-style-type: none"> Weight loss programs (exceptions may apply) 	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Contact the Department of Labor's Employee Benefits Security Administration at 1-(866)-444-3272 or www.dol.gov/ebsa/healthreform. 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, call (888)-619-5364 or (469)-423-6100. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-(866)-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). For additional information contact: Texas Department of Insurance; 333 Guadalupe; Austin, TX 78701; (800) 578-4677; <http://www.tdi.texas.gov/index.html>. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 (888)-619-5364 o (469) 423-6100.

————— *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 <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$810
Copayments	\$0
Coinsurance	\$2,380
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$3,251

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$5,601
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$850
Copayments	\$0
Coinsurance	\$1,730
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,750

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$810
Copayments	\$0
Coinsurance	\$399
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,209

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" located in the chart on page one.

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