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?	$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.	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?	In-network preventive care as required by the Affordable Care Act. May not exceed the Plan's Reasonable Charge. Deductible does not apply to hospice services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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.
What is the out-of-pocket limit for this plan?	**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 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, balance billed charges, health care this plan does not cover, penalties, charges in excess of usual, customary and reasonable, 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.

Will you pay less if you use a network provider?	Yes. For a list of PPO providers, go to www.BCBSIL.com or call (800) 810-2583	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
		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 deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Note: You are responsible for Non-PPO expenses above the PPO allowed amount.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge. Deductible does not apply	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. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive care. Then check what your plan will pay for.
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	Note: You are responsible for Non-PPO expenses above the PPO allowed amount.
	Imaging (CT/PET scans, MRIs)			
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; no charge thereafter	Not Covered	Deductible & coinsurance amounts count toward in-network and out-of-pocket limit.
	Preferred brand drugs	100% until $50 deductible met; 40% coinsurance until out-of-pocket limit met; no charge thereafter		
	Non-preferred brand drugs			
	Specialty drugs			

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	Note: You are responsible for Non-PPO expenses above the PPO allowed amount.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	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			
If you have a hospital stay	Facility fee (e.g., hospital room)	100% until deductible met; 20% coinsurance thereafter	100% until deductible met; 40% coinsurance thereafter	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. Semi-private room rate applies (if none available, allowed amount equals 90% of lowest daily private room rate). Note: You are responsible for Non-PPO expenses above the PPO allowed amount.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	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. Note: You are responsible for Non-PPO expenses above the PPO allowed amount.
	Inpatient services			
If you are pregnant	Office visits	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. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing does not apply for preventive care services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
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.

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 need help recovering or have other special health needs	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	100% until deductible met; 40% coinsurance 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.
	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 services	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	Children's 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.
	Children's 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	
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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	• 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, usual, customary and reasonable and medical necessity)	• Custodial Care
• Dental care (Adult)	• Dental care (children/dependent)	• 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (exceptions may apply)	• Chiropractic care (limitations apply)	• Private-duty nursing (limitations apply
• Routine eye care (Adult)	• 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**
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 (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 plan's overall deductible	$1,000
Specialist coinsurance	20%
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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,040
Copayments	$0
Coinsurance	$2,340
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,440**

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 coinsurance	20%
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,050
Copayments	$0
Coinsurance	$1,230
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,340**

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

The plan's overall deductible	$1,000
Specialist coinsurance	20%
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

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