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 1-800-527-0320. 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.dol.gov/ebsa/healthreform or call 1-800-527-0320 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/individual, $800/family per calendar year.	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. Prescription drugs, in-network preventive care, dental services and vision 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. 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50/individual, $100/family per calendar year for dental services. $200 for out-of-network hospital charges per person per 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?	Medical plan network providers: $4,400/individual, $8,800/family per calendar year (includes overall deductible). Prescription drugs (in-network): $2,200/ individual, $4,400/family per calendar year. Out-of-network providers: no out-of-pocket limit.	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-billing charges, non-Essential Health Benefits, out-of-network coinsurance, penalties for failure to obtain preauthorization, dental services, vision services, out-of-network hospital coinsurance, COB amounts, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com 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
		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	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Specialist visit	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	45% coinsurance, plus balance-billing charges	Subject to age and frequency limitations. 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	45% coinsurance, plus balance-billing charges	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance, plus balance-billing charges	None

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.sav-rx.com	Generic drugs	Retail and Mail Order: $10 copay per prescription	Same as in-network, plus balance-billing charges	Deductible does not apply. Retail prescription drugs limited to up to 34-day supply; mail order prescription drugs limited to up to 102-day supply; specialty drugs limited to up to 30-day supply. Where generic equivalent is available and medically appropriate, member pays brand copay plus difference in cost between brand and generic, and the difference in cost for the brand name drug does not count toward the out-of-pocket limit. No benefits for prescription drugs filled at Wal-Mart. No charge for ACA-required generic preventive drugs, such as contraceptives, or brand name preventive drugs if a generic is medically inappropriate.
	Preferred brand drugs	Retail: $30 copay for prescriptions that cost up to $150 and 30% coinsurance for prescriptions that cost over $150; Mail Order: $40 copay	Same as in-network, plus balance-billing charges	
	Non-preferred brand drugs	Retail: $45 copay for prescriptions that cost up to $150 and 30% coinsurance for prescriptions that cost over $150; Mail Order: $55 copay	Same as in-network, plus balance-billing charges	
	Specialty drugs	Retail and Mail Order: 30% coinsurance up to a maximum of $100 per prescription	Same as in-network, plus balance-billing charges	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Physician/surgeon fees	20% coinsurance	45% coinsurance, plus balance-billing charges	None

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 immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Must be in connection with an emergency medical condition (i.e., acute symptoms that a prudent layperson with average knowledge of health and medicine would expect that in the absence of medical attention would place the individual's health in serious jeopardy, or seriously impair body functions, organs, or parts). Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	Ground transportation: 20% coinsurance, plus balance-billing charges. Air transportation: 20% coinsurance	Limited to ground or air transportation to/from nearest facility able to provide necessary treatment. Must be in connection with an emergency medical condition.
	Urgent care	20% coinsurance	45% coinsurance, plus balance-billing charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance, plus balance-billing charges	Preauthorization required or benefits reduced 50%; maximum reduction is $250. Private room charges in excess of the hospital's average charge for semi-private room accommodations are not covered.
	Physician/surgeon fees	20% coinsurance	45% coinsurance, plus balance-billing charges	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Inpatient services	20% coinsurance	45% coinsurance, plus balance-billing charges	Preauthorization required or benefits reduced 50%; maximum reduction is $250.

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 are pregnant	Office visits	20% coinsurance	45% coinsurance, plus balance-billing charges	Cost sharing does not apply to in-network preventive services. Prenatal care (other than preventive screenings required under the Affordable Care Act) is not covered for dependent children. Delivery charges are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	45% coinsurance, plus balance-billing charges	
	Childbirth/delivery facility services	20% coinsurance	45% coinsurance, plus balance-billing charges	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Rehabilitation services	20% coinsurance for speech and physical therapy	45% coinsurance, plus balance-billing charges for speech and physical therapy	Speech therapy must be to restore speech loss, or correct impairment, due to (1) a congenital defect for which corrective surgery has been performed, or (2) an injury or sickness. Occupational therapy not covered.
	Habilitation services	20% coinsurance for speech and physical therapy	45% coinsurance, plus balance-billing charges for speech and physical therapy	
	Skilled nursing care	20% coinsurance	45% coinsurance, plus balance-billing charges	None
	Durable medical equipment	20% coinsurance	45% coinsurance, plus balance-billing charges	Limited to least expensive of appropriate equipment.
	Hospice services	20% coinsurance	20% coinsurance, plus balance-billing charges	None

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 your child needs dental or eye care	Children's eye exam	$25 copay; deductible does not apply	No charge up to $45, then 100%; deductible does not apply	Limited to one exam per calendar year. These benefits are administered separately from the medical plan. Your cost sharing does not count toward the plan's out-of-pocket limit.
	Children's glasses	Lenses: $25 copay; frames: no charge up to $130, then 80%; deductible does not apply	Lenses: No charge for single vision lenses up to $30, then 100%; frames: no charge up to $70, then 100%; deductible does not apply	Limited to lenses once each calendar year and frames once each two consecutive calendar years. These benefits are administered separately from the medical plan. Your cost sharing does not count toward the plan's out-of-pocket limit.
	Children's dental check-up	No charge; dental deductible does not apply	No charge; dental deductible does not apply	Dental services limited to $1,250 per person per calendar year for network (PPO) providers and $1,000 per person per calendar year for out-of-network (Premier) providers. These benefits are administered separately from the medical plan.

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.)

- Cosmetic surgery (except when necessary to repair disfigurement due to an accidental injury or in connection with a mastectomy)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except as required by the Affordable Care Act)

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

- Acupuncture (limited to 52 visits per calendar year, combined with chiropractic)
- Bariatric surgery (if medically necessary)
- Chiropractic care (limited to 52 visits per calendar year, combined with acupuncture)
- Dental care (Adult) (limited to $1,000 per person per calendar year)
- Hearing aids (limited to total payment of $2,500 per hearing aid; limited to two hearing aids per person in a five calendar year period)
- Private-duty nursing (only if services require skills, training and knowledge of licensed nurse)
- Routine eye care (Adult)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 on how 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: 1-800-527-0320. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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. 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 1-800-527-0320.

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	$400
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments (Rx)	$10
Coinsurance	$2,360
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,830

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

The plan's overall deductible	$400
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments (Rx)	$930
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,480

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

The plan's overall deductible	$400
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$480
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$890

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