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?	$300/individual, $600/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?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
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 full cost of your care (other than for prescription drugs) if you use an out-of-network provider. 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	Not covered	None
	Specialist visit	20% coinsurance	Not covered	None
	Preventive care/screening/ immunization	Not covered	Not covered	You must pay 100% of these expenses, even in-network, except that school-required immunizations are covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None
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	10% coinsurance	10% coinsurance	None
	Brand drugs	25% coinsurance	25% coinsurance	No benefits are available for a brand name drug for which a generic equivalent is available. This applies even if your physician prescribes a brand name drug for which there is a generic equivalent available and indicates "dispense as written."
	Specialty drugs	Not covered, except as noted under "Limitations, Exceptions, & Other Important Information"	Not covered, except as noted under "Limitations, Exceptions, & Other Important Information"	Specialty drugs administered in a physician's office will be covered up to a maximum of two times for each newly prescribed specialty drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Coverage limited to lesser of 10 hospital days (inpatient or outpatient), or one surgery or admission per calendar year.
	Physician/surgeon fees	20% coinsurance	Not covered	None

<table>
<tr><th rowspan="2">Common Medical Event</th><th rowspan="2">Services You May Need</th><th colspan="2">What You Will Pay</th><th rowspan="2">Limitations, Exceptions, & Other Important Information</th></tr>
<tr><th>Network Provider (You will pay the least)</th><th>Out-of-Network Provider (You will pay the most)</th></tr>
<tr><td rowspan="3">If you need immediate medical attention</td><td>Emergency room care</td><td>20% coinsurance</td><td>20% coinsurance</td><td>Must be in connection with an emergency medical condition. Professional/physician charges may be billed separately.</td></tr>
<tr><td>Emergency medical transportation</td><td>20% coinsurance</td><td>20% coinsurance</td><td>Limited to ground or air transportation to/from nearest facility able to provide necessary treatment. Must be in connection with an emergency medical condition.</td></tr>
<tr><td>Urgent care</td><td>20% coinsurance</td><td>20% coinsurance</td><td>None</td></tr>
<tr><td rowspan="2">If you have a hospital stay</td><td>Facility fee (e.g., hospital room)</td><td>20% coinsurance</td><td>Not covered</td><td>Coverage limited to lesser of 10 hospital days (inpatient or outpatient), or one surgery or admission per calendar year. Preauthorization required or benefits reduced 50%; maximum reduction is $250 (or per BCBS provider sanction). Private room charges in excess of the hospital's average charge for semi-private room accommodations are not covered.</td></tr>
<tr><td>Physician/surgeon fees</td><td>20% coinsurance</td><td>Not covered</td><td>None</td></tr>
<tr><td rowspan="2">If you need mental health, behavioral health, or substance abuse services</td><td>Outpatient services</td><td>20% coinsurance</td><td>Not covered</td><td>None</td></tr>
<tr><td>Inpatient services</td><td>20% coinsurance</td><td>Not covered</td><td>Coverage limited to lesser of 10 hospital days (inpatient or outpatient), or one surgery or admission per calendar year. Preauthorization required or benefits reduced 50%; maximum reduction is $250 (or per BCBS provider sanction).</td></tr>
<tr><td rowspan="3">If you are pregnant</td><td>Office visits</td><td>20% coinsurance</td><td>Not covered</td><td>Not covered for dependent children.</td></tr>
<tr><td>Childbirth/delivery professional services</td><td>20% coinsurance</td><td>Not covered</td><td rowspan="2">Not covered for dependent children.</td></tr>
<tr><td>Childbirth/delivery facility services</td><td>20% coinsurance</td><td>Not covered</td></tr>
</table>

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	Home health care	20% coinsurance	Not covered	None
	Rehabilitation services	20% coinsurance	Not covered	Physical therapy limited to 15-visit maximum per occurrence. 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	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	None
	Durable medical equipment	20% coinsurance	Not covered	Limited to least expensive of appropriate equipment.
	Hospice services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
If your child needs dental or eye care	Children's eye exam	20% discount available through VSP	Not covered	Limited to one eye exam per calendar year. These benefits are administered separately from the medical plan. The medical plan's deductible does not apply to vision services.
	Children's glasses	20% discount available through VSP	Not covered	None. These benefits are administered separately from the medical plan. The medical plan's deductible does not apply to vision services.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

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 • Children's dental check-up • Chiropractic care • Cosmetic surgery (except for treatment of an accidental injury where treatment is begun within six months after the accident, treatment of a congenital anomaly in a child or in connection with a mastectomy) • Dental care (Adult) • Hearing aids • Hospice services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Preventive care/screening/immunization (school-required immunizations are covered) • Private-duty nursing • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Routine eye care (Adult)(covered under separate vision plan)

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
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	$300
■ 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	$300
Copayments	$0
Coinsurance	$2,450
What isn't covered	
Limits or exclusions	$110
The total Peg would pay is	$2,860

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

■ The plan's overall deductible	$300
■ 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	$300
Copayments	$0
Coinsurance	$1,190
What isn't covered	
Limits or exclusions	$180
The total Joe would pay is	$1,670

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

■ The plan's overall deductible	$300
■ 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	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

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