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?	Yes. $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?	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 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	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	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	No benefits are available for prescriptions obtained from Walmart or Sam's Club. 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 administered in a physician's office will be covered up to a maximum of two times for each newly prescribed specialty drug.
	Brand drugs	25% coinsurance	25% coinsurance	
	Specialty drugs	Not covered, except as noted under "Limitations, Exceptions, & Other Important Information"	Not covered, except as noted under "Limitations, Exceptions, & Other Important Information"	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	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. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to ground or air transportation to/from nearest facility able to provide necessary treatment. Must be in connection with bona fide emergency.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance after $200 hospital deductible per person per admission	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year. Preauthorization required or benefits reduced 50%; maximum reduction is $250 (or per BCBS provider sanction).
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year. Preauthorization required or benefits reduced 50%; maximum reduction is $250 (or per BCBS provider sanction).
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Not covered for dependent children.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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	50% coinsurance	None
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical therapy limited to 20 visits per calendar year. 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	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	None
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to least expensive of appropriate treatment or 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	$50 copay with purchase of complete pair of prescription glasses; 20% discount without purchase of complete pair of prescription glasses.	Not covered	Limited to one eye exam per calendar year. Deductible does not apply.
	Children's glasses	Lenses: $40 copay for single vision lenses with purchase of complete pair of prescription glasses; Frames: 25% discount with purchase of complete pair of prescription glasses	Not covered	Deductible does not apply.
	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
- 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)

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	$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.