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 contact the Plan at 1-866-434-2200. 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 1-866-434-2200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000**/Person; **$3,000**/Family. Out-of-Network: **$1,000**/Person; **$3,000**/Family. Doesn't apply to certain preventive care for PPO	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. Certain preventive care for PPO	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. $100 for prescription drugs. 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?	Yes. **Medical**: In-Network: **$6,000**/Person; **$12,000**/Family. Out-of-Network: **$10,000**/Person; **$20,000**/Family. **Pharmacy:** In-Network **$600**/Person**; $1,200**/Family	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, out-of-network deductibles and health care this plan doesn't cover.	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. See **www.bcbsil.com** or call **1-800-810-2583** for a list of in-network providers.	his 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	$40 Copay; Minute Clinics: $30 Copay.	30% Coinsurance after deductible met. Minute Clinics: N/A	Expenses that exceed usual, customary and reasonable charges are not covered.
	Specialist visit	$40 Copay	30% Coinsurance after deductible met	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Regular care & immunizations: 30% Coinsurance after deductible met; Annual Physical: 40% after deductible met ($250 maximum)	Benefit coverage as mandated by the Affordable Care Act. 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)	No charge first $500; 20% Coinsurance after deductible met	30% Coinsurance after deductible met	Expenses that exceed usual, customary and reasonable charges are not covered. Preauthorization required for Imaging.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-866-434-2200.	Generic drugs	**Generic:** $15 Copay for 30-day supply (retail); $30 Copay for 90-day supply (mail order).	No Coverage.	$100 deductible for must be met first. Includes drugs that are listed on the Plan's Formulary. Mail order mandatory after 2nd refill. Preferred/Non-preferred Brand drugs - when generic equivalent is available, you also pay the difference in cost.
	Preferred brand drugs	**Preferred Brand:** $50 Copay for 30-day supply (retail); $65 Copay for 90-day supply (mail order)		
	Non-preferred brand drugs	$75 Copay for 30-day supply (retail); $125 Copay for 90-day supply (mail order)	No Coverage.	$100 deductible must be met first. Drugs are not listed on the Plan's Formulary. You must pay the difference between the price of the Formulary/Preferred Drug and the cost of the Non-Preferred Drug.
	Specialty drugs	10% Coinsurance of cost of drug (Max $150)	No Coverage.	Mail order is mandatory after the first Rx is filled.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Penalty of a 50% benefit reduction if not pre-certified.
	Physician/surgeon fees			

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	$200 Copay + 20% Coinsurance; Deductible waived.	$200 Copay + 20% Coinsurance; Deductible waived	In-Network copay waived if admitted to hospital. No cost for first $200 for accidental injury.
	Emergency medical transportation	20% Coinsurance after deductible met	20% Coinsurance after deductible met	Air transportation covered only if Medically Necessary because of life-threatening injury or illness.
	Urgent care	20% Coinsurance after deductible met	40% Coinsurance after deductible met	No cost for first $200 for accidental injury.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Penalty of a 50% benefit reduction if not pre-certified. Facility: covers semi-private room & related services.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Inpatient: penalty of 50% benefit reduction if not pre-certified.
	Inpatient services			
If you are pregnant	Office visits	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). All services related to surrogacy are excluded.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Must be Medicare certified or accredited by Joint Commission on the Accreditation of Health Care Organizations. Limit: 60 visits/yr.
	Rehabilitation services	20% Coinsurance after deductible met	40% Coinsurance after deductible met	No Plan benefits provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts). Other limits apply.
	Habilitation services	Not Covered.	Not Covered	Not applicable.

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	Skilled nursing care	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Must be admitted within 24 hours following a hospital stay. Services must be a continuation of treatment for the hospitalized condition.
	Durable medical equipment	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Rental cost can't exceed purchase cost. Other limitations apply.
	Hospice services	20% Coinsurance after deductible met	40% Coinsurance after deductible met	Penalty of 50% benefit reduction if not pre-certified. Must be certified by Medicare or approved by Joint Commission on Accreditation of Health Care Organizations.
If your child needs dental or eye care	Children's eye exam	Not Covered.	Not Covered.	Not applicable.
	Children's glasses			
	Children's dental check-up			

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	• Cosmetic surgery (some exceptions apply)
• Dental care (Adult)	• Hearing aids	• Infertility treatment
• Long-term care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Routine foot care	• Weight loss programs	• Surrogate pregnancy

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

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 or the Texas Department of Insurance at 1-800-578-4677 or http://www.tdi.texas.gov/index.html. 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, contact the plan at 1-866-434-2200. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-(866)-444-3272 or www.dol.gov/ebsa/healthreform or the Texas Department of Insurance at 1-800-578-4677 or http://www.tdi.texas.gov/index.html. Additionally, a consumer assistance program can help you file your appeal. 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 1-866-434-2200.

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

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 copay	$40
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	$80
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,380**

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 copay	$40
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 **	$1,100
Copayments	$1,420
Coinsurance	$140
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,720**

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

The plan's overall deductible	$1,000
Specialist copay	$40
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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$320
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

** 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.