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 the plan at 713-645-1076.
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 1-800-682-7473 or 713-645-1076 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,250**/individual, **$3,600**/family	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. However, if a family has more than 3 members, the amount that all family members pay cumulatively towards the family deductible can be used to satisfy the family deductible amount.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and care received under the $300 supplemental accident benefit 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
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?	Network providers: **$5,100**/individual, **$10,200**/family; Out-of-network providers: **$10,800**/individual	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, penalties for failure to obtain preauthorization 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/provider/index.html 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	25% coinsurance	50% coinsurance	None
	Specialist visit	25% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	25% coinsurance for outpatient well-baby care (from birth up to one year) up to $500, then 90% coinsurance; 25% coinsurance for other preventive services	Age and frequency limits apply. 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)	25% coinsurance	50% coinsurance	Preauthorization required for outpatient tests or procedures involving an invasion of the body or benefits paid at 50% coinsurance.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	
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	50% coinsurance (based on the actual cost of the drug)	Not covered	Limited to 30-day supply retail and 90-day supply mail order. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Brand name drugs	50% coinsurance (based on the actual cost of the drug)	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory	25% coinsurance	Not covered	Preauthorization required on all outpatient

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)	
surgery	surgery center)			surgical procedures or benefits paid at 50% coinsurance.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	25% coinsurance	50% coinsurance	Limited to transportation to/from the nearest hospital where treatment can be given.
	Urgent care	25% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization required or benefits paid at 50% coinsurance.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Inpatient services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
If you are pregnant	Office visits	25% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Plan of care must meet specific criteria.
	Rehabilitation services	25% coinsurance	50% coinsurance	None
	Habilitation services	25% coinsurance	50% coinsurance	None
	Skilled nursing care	25% coinsurance	50% coinsurance	None
	Durable medical equipment	25% coinsurance	50% coinsurance	Benefits for the rental of durable medical equipment may not exceed the purchase price.
	Hospice services	25% 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 your child needs dental or eye care	Children's eye exam	$10 copayment	No charge up to $50, then 100%	Limited to one eye exam per calendar year. $50 limit not applicable to pediatric eye exams for individuals under age 19.
	Children's glasses	$25 copayment, plus amounts in excess of plan's allowed amount for frames	No charge up to allowed amount of $50 for single vision lenses and up to allowed amount of $70 for frames, then 100%	Limited to one pair per calendar year. Out-of-network allowed amount is $75 for bifocals and $100 for trifocals. Dollar limits not applicable to glasses for individuals under age 19.
	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
- Children's dental check-up
- Cosmetic surgery (unless because of an accidental injury, incidental to or following surgery that results from trauma, infection or other disease, or because of congenital disease or anomaly that has resulted in a functional defect)
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Mental health/behavioral health services
- Substance abuse services
- Weight loss programs (except as required under the Affordable Care Act)

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

- Bariatric surgery (for treatment of morbid obesity in certain limited circumstances)
- Chiropractic care (limited to maximum reimbursement of $500 per year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if medically necessary and provided by a registered nurse or licensed practical nurse)
- Routine eye care (Adult)
- Routine foot care (limited to maximum of 50 visits per year)

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 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 Blue Cross Blue Shield at 1-800-367-8309. 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.

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 1-800-810-2583.

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	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$2,810
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,120**

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

The plan's overall deductible	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,750**

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

The plan's overall deductible	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,420**

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