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 of covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsil.com or by calling 1-800-862-3386. 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 **1-855-756-4448** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network:** **$1,200 /** Individual; **$2,400 /** Family **Out-of-Network:** **$2,400 /** Individual; **$4,800 /** Family	Generally, you must pay all 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. **Preventative care** and Chiropractic 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 **co-payment** or **co-insurance** may apply. For example, this **plan** covers certain **preventative services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventative 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?	**In-Network Medical:** **$4,000** / Individual; **$8,000 /** Family **Out-of-Network Medical:** **$8,400 /** Individual; **$16,800** / Family **In-Network Prescription:** **$3,150 /** Individual; **$6,300** / 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 may 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?	**Co-payments** for certain services, **premiums**, **balance-billed** charges, non-PPO **co-insurance**, hearing aid **co-insurance**, and health care this **plan** does not 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.** Visit www.bcbsil.com or **call 1-800-810-2583** 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 **co-payments** and **co-insurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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 copay/visit	40% coinsurance	----------None----------
	Specialist visit	$60 copay/visit	40% coinsurance	----------None----------
	Preventive care/ **screening**/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	15% coinsurance	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10/30-day prescription $20/90-day prescription	Not Covered	Maintenance drugs must use CVS Mail Order or a CVS Pharmacy; up to a 90-day supply, max. 2 fills at other retail pharmacies for maintenance drugs, then must use CVS Mail Order or CVS Pharmacy. Call 1-800-966-5772 for CVS Mail Order. 30-day supply for non-maintenance drugs can be filled at any in-network pharmacy **Specialty drugs** must be filled through CVS Specialty Connect at 1-800-237-2767. **$3,150**/individual and **$6,300**/family annual max. **out-of-pocket limit** on in-network prescriptions. Call CVS at 1-800-566-5693 for customer service.
	Preferred brand drugs	25% of cost; $35 min/$50 max copay/30-day prescription. 25% of cost; $70 min/$100 max/90-day prescription.	Not Covered	
	Non-preferred brand drugs	30% of cost; $55 min/$100 max/30-day prescription. 30% of cost; $110 min/$200 max/90-day prescription.	Not Covered	
	Specialty drugs	**Preferred Brand Specialty:** 25% of cost; $35 min/$50 max copay/30-day prescription. 25% of cost; $70 min/$100 max/90-day prescription. **Non-Preferred Brand Specialty:** 30% of cost; $55 min/$100 max/30-day prescription. 30% of cost; $110 min/$200 max/90-day prescription.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	----------None----------
	Physician/surgeon fees	15% coinsurance	40% coinsurance	
If you need immediate medical attention	**Emergency room care**	15% coinsurance	15% coinsurance	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	15% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	**Preauthorization** is required. Failure to obtain preauthorization will result in a $200 penalty. Non-emergency admissions must be preauthorized a minimum of 3 days prior to treatment. Emergency admissions must be preauthorized within 48 hours. Childbirth: Preauthorization is required for extended hospital stays that exceed 48 hours/vaginal delivery; 96 hours/cesarean section. Call BCBSIL Medical Service Advisory at 1-800-635-1928 for further information.
	Physician/surgeon fee	15% coinsurance	40% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25.00 copay/office visit	40% coinsurance	Prior to inpatient mental health or substance abuse care, call BCBSIL Behavioral Health at 1-800-851-7498. Member's Assistance Program (MAP), call ERS at 1-800-292-2780.
	Inpatient services	15% coinsurance	40% coinsurance	
If you are pregnant	Office Visits	$25.00 copay/office visit	40% coinsurance	Copay only applies to first prenatal visit/pregnancy. **Cost sharing** does not apply for **preventive services**. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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**	15% coinsurance	40% coinsurance	Medical review required. Call 1-800-862-3386.
	Rehabilitation services	15% coinsurance	40% coinsurance	30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL at 1-800-862-3386.
	Habilitation services	15% coinsurance	40% coinsurance	30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL 1-800-862-3386.
	Skilled nursing care	15% coinsurance	40% coinsurance	Medical review required. Call 1-800-862-3386.
	Durable medical equipment	15% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Some **durable medical equipment** (**DME**) may require medical review. Call BCBSIL at 1-800-862-3386.
	Hospice services	15% coinsurance	40% coinsurance	Medical review required. Life expectancy must be 6 months or less. Call BCBSIL at 1-800-862-3386.
If your child needs dental or eye care	Children's eye exam	No charge for child age 0-18 $30.00 copay for child age 19-26	$30.00 copay	Child must be an Eligible Dependent under Plan. **Out-of-Network:** Child age 19-26, Plan will reimburse up to $45 on one exam per year after the copay is satisfied. Call VSP at 1-800-877-7195.
	Children's glasses	$20.00 copay	$20.00 copay + 20% coinsurance for child age 0-18	Child must be an Eligible Dependent under Plan. **In-Network:** Child age 19-26, Participant is responsible for frame costs above $125, but discounted by 20%. **Out-of-Network:** Child age 19-26, reimbursement up to specified limits depending on the type of lens and frame. Call VSP at 1-800-877-7195.
	Children's dental check-up	No charge for child age 0-26	No charge for child age 0-26, unless over U&C charges	Child must be an Eligible Dependent under Plan. No charge applies to eligible preventative care services. **Child age 0-18:** Preventative care services do not apply to dental maximum. **Child age 19-26**: Preventative care services do apply to dental maximum. Call Dental Network of America at 1-800-862-3386.

- Acupuncture (30 visit limit/calendar year)
- Chiropractic care (30 visit limit/calendar year)
- Dental Care (Adult)
- Hearing aids ($75 exam, 80% of first $500 of U&C charges per ear; $400 maximum/calendar year); limits do not apply to bone anchored hearing aids for eligible dependent children age 0-19).
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the United States
- Private-duty nursing (except inpatient private duty nursing)
- Routine eye care (Adult)
- Routine foot care (when determined to be medically necessary)

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.)

- Bariatric surgery (except in cases of morbid obesity)
- Cosmetic surgery (unless corrects the effect of an injury, congenital deformity or deformity resulting from disease or is medically necessary)
- Infertility treatment
- Long-term care
- Weight loss programs (except in cases of morbid obesity)

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 U.S. Department of Labor, 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 you 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 information about your rights, this notice, or assistance, contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 1-800-862-3386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-3386.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-862-3386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-862-3386.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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 the 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	$1,200
Specialist copayment	$60
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$12,732**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copays	$108
Coinsurance	$1,321
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,689**

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

The plan's overall deductible	$1,200
Specialist copayment	$60
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,200
Copays	$1,074
Coinsurance	$99
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,429**

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

The plan's overall deductible	$1,200
Specialist copayment	$60
Hospital (facility) coinsurance	15%
Other coinsurance	15%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray)*
Durable medical equipment (*crutches)*
Rehabilitation services

Total Example Cost	**$1,926**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$859
Copays	$280
Coinsurance	$84
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,223**