**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, [insert contact information]. 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?** | **$600**/individual/calendar year<br>**$1,200**/family/calendar year | 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 met the annual deductible amount. But a copayment, or coinsurance, 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** (calendar year)<br>**$3,000**/individual or family<br>**Out-of-Network Medical** (calendar year)<br>**$5,700**/individual or family<br>**In-Network Prescription** (calendar year)<br>**$5,550**/individual or 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, penalties for failure to obtain preauthorization for services, hearing aid PPO 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 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 copay/office visit | 20% coinsurance | None |
| | Specialist visit | $60 copay/office visit | 20% coinsurance | None |
| | Preventive care, screening, immunization | No charge | 20% coinsurance | You may have to pay for services that aren't preventative services. Ask your provider if the services are preventative services, then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 20% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.caremark.com or 1-800-566-5693 | Generic drugs | $10/30-day prescription<br>$20/90-day prescription | Not Covered | You can obtain two initial 30-day fills of a maintenance drug at any retail pharmacy. After the two initial fills, you must obtain a 90-day fill via CVS Mail Order or CVS Pharmacy. Call 1-800-966-5772 for CVS Mail Order.<br>30-day supply for non-maintenance drugs can be filled at any in-network pharmacy. |
| | Preferred brand drugs | 25% of cost; $30 min/$50 max. copay/30-day prescription.<br>25% of cost; $60 min/$100 max copay/90-day prescription. | Not Covered | |
| | Non-preferred brand drugs | 30% of cost; $50 min/$100 max copay/30- day prescription.<br>30% of cost; $100 min/$200 max copay/90-day prescription. | Not Covered | |

[* For more information about limitations and exceptions, see the plan or policy document at 1-800-862-3386.]

| 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) | |
| | Specialty drugs | **Preferred Brand Specialty:** 25% of cost; $30 min/$50 max copay/30-day prescription. 25% of cost; $60 min/$100 max copay/90-day prescription. **Non-Preferred Brand Specialty:** 30% of cost; $50 min/$100 max copay/30-day prescription. 30% of cost; $100 min/$200 max copay/90-day prescription. | Not Covered | A penalty may be applied if a brand drug is requested when a generic is available. Specialty drugs must be filled through CVS Specialty Connect at 1-800-237-2767. $5,700/individual and family annual max. out-of-pocket limit on in-network prescriptions. Call CVS at 1-800-566-5693 for customer service. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | 10% coinsurance | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 20% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in a $200 penalty. Non-emergency admissions must be preauthorized a minimum of 3 days prior to treatment. Emergency admissions must be authorized 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 fees | 10% coinsurance | 20% 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 mental health, behavioral health, or substance abuse services** | Outpatient services | $60 copay/office visit | 20% coinsurance | Preauthorization is required for inpatient services. Failure to obtain preauthorization may result in a $200 penalty. Non-emergency admissions must be preauthorized a minimum of 3 days prior to treatment. Emergency admissions must be authorized within 48 hours. Prior to inpatient mental health or substance abuse care, call BCBSIL Behavioral Health at 1-800-851-7498. Call ERS, the Member's Assistance Program (MAP), at 1-800-292-2780. |
| | Inpatient services | 10% coinsurance | 20% coinsurance | |
| **If you are pregnant** | Office visits | $25 copay/office visit | 20% coinsurance | Copay only applies to first prenatal visit/pregnancy. Cost sharing does not apply for preventative services. Depending on the type of service, coinsurance may apply. |
| | Childbirth/delivery professional services | 10% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 20% coinsurance | Medical review required. Call BCBSIL at 1-800-862-3386. |
| | Rehabilitation services | 10% coinsurance | 20% coinsurance | 30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL at 1-800-862-3386. |
| | Habilitation services | 10% coinsurance | 20% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 20% coinsurance | Medical review required. Call 1-800-862-3386. |
| | Durable medical equipment | 10% coinsurance | 20% coinsurance | Benefits are limited to items used to serve a medical purpose. Some durable medical equipment (DME) may require medical review. Call BCBSIL 1-800-862-3386. |
| | Hospice services | 10% coinsurance | 20% coinsurance | Medical review required. Life expectancy must be 6 months or less. Call BCBSIL at 1-800-862-3386. |

[* For more information about limitations and exceptions, see the plan or policy document at 1-800-862-3386.]

| 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 | $0 for ages 0 – 18<br>$30 **copay** for ages 19 - 26 | $30 **copay** | Child must be an Eligible Dependent under Plan. **Out-of-Network**: Children ages 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 **copay** | $20 **copay** + 20% **coinsurance** for ages 0-18 | Child must be an Eligible Dependent under Plan.<br>**In-Network**: Children ages 19-26 is responsible for frame costs above $125 but discounted by 20%.<br>**Out-of-Network**: Children ages 19-26 reimbursement up to specified limits depending on the type of lens/frame. Call VSP at 1-800-877-7195. |
| | Children's dental check-up | $0 for ages 0 - 26 | $0 for ages 0 – 26, unless exceeds U&C charges | Child must be an Eligible Dependent under Plan. No charge applies to eligible **preventative services**.<br>**Children ages 0-18: Preventative services** do not apply to dental maximum.<br>**Children ages 19-26: Preventative services** do apply to dental maximum. Call Dental Network of America at 1-800-862-3386. |

[* For more information about limitations and exceptions, see the **plan** or policy document at 1-800-862-3386.]

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

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (30 visit limit/calendar year | • Hearing aids ($75 exam, 80% of $2,500 per ear, $4,000 maximum benefit every 60 months not to exceed 2 hearing aids; limits do not apply to one anchored haring aid for eligible dependent children ages 0 - 19 | • Private-duty nursing (except inpatient private duty nursing) |
| • Chiropractic care (30 visit limit/calendar year | • Non-emergency care when traveling outside the United States | • Routine eye care (Adult and Children) |
| • Dental Care (Adult and Children | | • Routine foot care (when determined to be medically necessary) |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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**.

[* For more information about limitations and exceptions, see the **plan** or policy document at 1-800-862-3386.]

## 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.*



[* For more information about limitations and exceptions, see the plan or policy document at 1-800-862-3386.]

## 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 | $600 |
| Specialist | $60 |
| Hospital (facility) | 10% |
| Other | 10% |

**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 | $600 |
| Copayments | $60 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,300** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist | $60 |
| Hospital (facility) | 10% |
| Other | 10% |

**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 | $600 |
| Copayments | $1,000 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $1,400 |
| **The total Joe would pay is** | **$1,400** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist | $60 |
| Hospital (facility | 10% |
| Other | 10% |

**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 | $600 |
| Copayments | $300 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |

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