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 800-828-3116 or at www.bcbsil.com. 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 4 re W* n BT 0 g 0 Tw 44264 re W* 1* n BT16 6( )18 (t)18 (t)18 (tTg 0 Tw 321* n B3

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
		In-Network Provider (You will pay the least	Out-of-Network Provider (You will pay the most	
If you visit a health care				

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	

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 otherspecial health needs	Home health care	20% coinsurance, deductible does not apply	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	$25 copay/visit, deductible does not apply	40% coinsurance	Limited to 60 visits per benefit period for occupational therapy, 60 visits per benefit period for speech therapy, and 60 visits per benefit period for physical therapy. Preauthorization may be required.
	Habilitation services	$25 copay/visit,		

If your child needs dental or eye care	& K L O G U H Q ¶ V H \ H	No Charge deductible does not appl	40% coinsurance	See plan document for routine vision ex that are covered at No Charge for preventive services
	& K L O G U H Q ¶ V J O D	Not Covered	Not Covered	None
	& K L O G U H Q ¶ V G H Q	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or

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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For more information about your rights and obligations under the plan, you should contact the plan administrator. The Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the

Peg is Having a Baby	0 D Q D J L Q J 7 \ S H ' L D E H W H V	0 L D · V 6 L P S O H) U
(9 months of in-network prenatal care and a hospital delivery)	(a year of routine in-network care of a well controlled condition)	(in-network emergency room visit and foll up care)

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