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

_____?	For In-Network: $1,700 Individual/$3,400 Family For Out-of-Network: $3,400 Individual/$6,800 Family
Are there services covered before you mee your deductible?	Yes. Certain preventive care, services that charge a copay prescription drugs and emergency room services are covered before you meet your deductible
Are the e other deductibles for specific services?	No.
What is not included in the out-of-pocket limit?	Premium, balance billing charges, and health care this plan

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

This plan F R Y H U V V R P H L W H P V D Q G V H U Y L F H V deductible H amount. But 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 www.healthcare.gov/coverage/preven care benefits/

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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 S U R Y bfC e or clinic	Primary care visit to treat an i or illness	$30 copay/visit, deductible does not appl	40%	

Common Medical Event	Services You May Need	What You Will Pay	Limitations

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	20% coinsurance; deductible does not appl	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	$30 copay/visit; deductible does not appl	40% coinsurance	Limited to 60 visits per benefit period for T Q 0

If your child needs dental or eye care	& K L O G U H Q ¶ V H \ H	No Charge deductible does not apply	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 plan document for more information and a list of any other excluded services)		
Dental care (Adult)	Long term care	Weight loss programs
Hearing aids	Routine foot care (with the exception of perso with diagnosis of diabetes)	

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

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 plan at 1-800-283-3116, U 6 ' H S D U W P H Q W R I / D E R U ¶ V (P S O R \ H H % H Q H I L W V $ G P L Q L V W U D W L R Q at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For 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 Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rig D11.62 489.94 T (2Y17Q70.C2 Tf Tf 17b5 o)-5 (ran)-4 (c)10 (e)-3 (co)-5 (t38 53.784 03 12 Tfp3 12 Tf 484.15 518

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Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)	0 D Q D J L Q Type 2 Diabetes (a year of routine in-network care of a well controlled condition)	0 L D · V 6 L P S O H) U (in-network emergency room visit and foll up care)
The S O D overall deductible	$1,700	
Specialist copayment	$50	2 n 0. (0)Tj ET 1491gf 180.98 385.99 Td [( )-3 ( )-3 ( )-3 ( )8 ( )-3 ( )]TJ ET Q q 0 0 792 612 re W
Hospital (facility) both	$2000	20%

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

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who speaks a language as a second language. We do not discrimi on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.