



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 713-643-9300 or 1-866-236-3148. 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 713-643-9300 or 1-866-236-3148 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network providers:</u> \$500/individual, \$1,500/family; <u>Out-of-network providers:</u> \$1,500/individual, \$3,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. In- <u>network</u> primary care and specialist visits, in- <u>network</u> <u>preventive care</u> , certain in- <u>network</u> generic <u>prescription drugs</u> , in- <u>network</u> <u>home health care</u> , in- <u>network</u> <u>rehabilitation services</u> and in- <u>network</u> <u>habilitation services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$50/individual, \$150/family for dental. There are no other specific deductibles.	You must pay all of the costs for most of these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for most of these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network providers:</u> \$5,500/individual, \$11,000/family; <u>Out-of-network providers:</u> No <u>out-of-pocket limit</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , <u>out-of-network</u> <u>coinsurance</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of <u>network providers</u> . For a list of <u>network</u> mental health providers, call 1-800-851-7498	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$40 <u>copayment</u> per visit, then 20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	70% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copayment</u> per visit, then 20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	70% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge for preventive services mandated to be covered under the Affordable Care Act. <u>Deductible</u> does not apply.	70% <u>coinsurance</u>	Age and frequency limits apply as permitted by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> required on all invasive diagnostic procedures or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	70% <u>coinsurance</u>	

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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available by contacting the <u>plan</u> at 713-643-9300 or 1-866-236-3148	Generic drugs	For generic drugs with a purchase price of up to \$350: no charge, <u>deductible</u> does not apply. For generic drugs with a purchase price in excess of \$350: \$50 for a retail supply, \$100 for mail or walk in mail supply For specialty drugs 20% coinsurance.	For generic drugs with a purchase price of up to \$350: no charge, <u>deductible</u> does not apply. For generic drugs with a purchase price in excess of \$350: 20% <u>coinsurance</u>	Limited to 30-day supply. No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate. For brand name drugs with generic alternatives, you pay the amount specified and the difference in cost between the generic and brand name drug
	Brand name drugs	For brand name drugs that are obtained through a retail pharmacy \$75 For brand name drugs that are obtained through the mail or via walk in mail: \$150. For specialty drugs 20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> required or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. <u>Preauthorization</u> required for devices (except artificial organs) implanted by surgery into a body cavity to aid the function of an internal organ, or benefits will be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	70% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Must be for a "Medical Emergency." Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	70% <u>coinsurance</u>	Limited to transportation to the nearest hospital.

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)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	70% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> required out-of-network or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. <u>Preauthorization</u> required out-of-network for devices (except artificial organs) implanted by surgery into a body cavity to aid the function of an internal organ, or benefits will be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	70% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> ; substance abuse services not covered	70% <u>coinsurance</u> ; substance abuse services not covered	<u>Preauthorization</u> required out-of-network for partial hospitalizations or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. Substance abuse services not covered.
	Inpatient services	20% <u>coinsurance</u> ; substance abuse services not covered	70% <u>coinsurance</u> ; substance abuse services not covered	<u>Preauthorization</u> required out-of-network or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. Substance abuse services not covered.
If you are pregnant	Office visits	20% <u>coinsurance</u>	70% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Prenatal care (other than ACA-required preventive screenings and complications of pregnancy) is not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Delivery charges are not covered for dependent children except for complications of pregnancy. <u>Preauthorization</u>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	70% <u>coinsurance</u>	

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)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	70% <u>coinsurance</u>	required out-of-network or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement (only applies to hospital stays that last longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section).
If you need help recovering or have other special health needs	<u>Home health care</u>	\$40 <u>copayment</u> per visit, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply.	70% <u>coinsurance</u>	Preauthorization required or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. Limited to 30 visits per calendar year (in- <u>network</u> and <u>out-of-network</u> combined). Care must begin within 14 days after discharge from a hospital or <u>skilled nursing care</u> confinement.
	<u>Rehabilitation services</u>	\$40 <u>copayment</u> per visit per provider, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply.	70% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$40 <u>copayment</u> per visit per provider, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply.	70% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	70% <u>coinsurance</u>	Preauthorization required out-of-network or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement. Limited to 30 days per calendar year (in- <u>network</u> and <u>out-of-network</u> combined). Confinement must begin within 7 days immediately following a hospital confinement of at least 5 consecutive days.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	70% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	70% <u>coinsurance</u>	Preauthorization required out-of-network or benefits reduced by 10% up to a maximum penalty of \$1,000 per procedure, occurrence or confinement.

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 <u>copay</u> /exam	No charge up to \$45, then 100%.	Limited to one eye exam every calendar year. Separately administered by CIGNA Vision.
	Children's glasses	<u>Lenses</u> : \$15 <u>copay</u> ; frames: no charge up to \$130, then 100%.	<u>Lenses</u> : no charge up to lens allowance, then 100%; frames: no charge up to \$71, then 100%.	Limited to lenses every calendar year and frames every two calendar years. Separately administered by CIGNA Vision.
	Children's dental check-up	No charge; <u>deductible</u> does not apply; dental <u>deductible</u> does not apply.	No charge up to <u>allowed amount</u> , then 100%; <u>deductible</u> does not apply; dental <u>deductible</u> does not apply.	Limited to two per calendar year. Separately administered by CIGNA.

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 <u>excluded services</u> .)			
- Acupuncture - Bariatric surgery - Cosmetic surgery (except as required under the Women's Health and Cancer Rights Act)	- Hearing aids - Infertility treatment - Long-term care - Non-emergency care when traveling outside the U.S.	- Private-duty nursing - Routine foot care - Substance abuse services - Weight loss programs (except as required by the Affordable Care Act)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
Chiropractic care (manipulative chiropractic treatment limited to 10 visits per calendar year)	Dental care (Adult)(\$1,000 calendar year benefits maximum)	Routine eye care (Adult)	

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 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 plan at 713-643-9300 or 1-866-236-3148. 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

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.

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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40 + 20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,290
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,850

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40 + 20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$390
<u>Coinsurance</u>	\$780
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,670

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40 + 20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$320
<u>Coinsurance</u>	\$340
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,160