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 deductible?	Network providers: **$500**/individual, **$1,500**/family; Out-of-network providers: **$1,500**/individual, **$3,000**/family	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.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist visits, in-network preventive care, certain in-network generic prescription drugs, in-network home health care, in-network rehabilitation services and in-network habilitation 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 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles 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 deductible amount before this plan begins to pay for most of these services.
What is the out-of-pocket limit for this plan?	Network providers: **$5,500**/individual, **$11,000**/family; Out-of-network providers: No out-of-pocket limit	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 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?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization, out-of-network coinsurance and health care this plan doesn't 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. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers. For a list of network mental health providers, call 1-800-851-7498	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	$40 copayment per visit, then 20% coinsurance. Deductible does not apply.	70% coinsurance	None
	Specialist visit	$40 copayment per visit, then 20% coinsurance. Deductible does not apply.	70% coinsurance	None
	Preventive care/screening/ immunization	No charge for preventive services mandated to be covered under the Affordable Care Act. Deductible does not apply.	70% coinsurance	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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	70% coinsurance	Preauthorization 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% coinsurance	70% coinsurance	

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 **prescription drug coverage** is available by contacting the plan at 713-643-9300 or 1-866-236-3148	Generic drugs	For generic drugs with a purchase price of up to $350: no charge, deductible 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, deductible does not apply. For generic drugs with a purchase price in excess of $350: 20% coinsurance	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% coinsurance	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	70% coinsurance	Preauthorization required or benefits reduced by 10% up to a maximum penalty of $1,000 per procedure, occurrence or confinement. Preauthorization 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% coinsurance	70% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Must be for a "Medical Emergency." Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	70% coinsurance	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)	
	Urgent care	20% coinsurance	70% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	70% coinsurance	Preauthorization required out-of-network or benefits reduced by 10% up to a maximum penalty of $1,000 per procedure, occurrence or confinement. Preauthorization 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% coinsurance	70% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance; substance abuse services not covered	70% coinsurance; substance abuse services not covered	Preauthorization 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% coinsurance; substance abuse services not covered	70% coinsurance; substance abuse services not covered	Preauthorization 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% coinsurance	70% coinsurance	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. Preauthorization
	Childbirth/delivery professional services	20% coinsurance	70% coinsurance	

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% coinsurance	70% coinsurance	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	Home health care	$40 copayment per visit, then 20% coinsurance; deductible does not apply.	70% coinsurance	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-network and out-of-network combined). Care must begin within 14 days after discharge from a hospital or skilled nursing care confinement.
	Rehabilitation services	$40 copayment per visit per provider, then 20% coinsurance; deductible does not apply.	70% coinsurance	None
	Habilitation services	$40 copayment per visit per provider, then 20% coinsurance; deductible does not apply.	70% coinsurance	None
	Skilled nursing care	20% coinsurance	70% coinsurance	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-network and out-of-network combined). Confinement must begin within 7 days immediately following a hospital confinement of at least 5 consecutive days.
	Durable medical equipment	20% coinsurance	70% coinsurance	None
	Hospice services	20% coinsurance	70% coinsurance	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 copay/exam	No charge up to $45, then 100%.	Limited to one eye exam every calendar year. Separately administered by CIGNA Vision.
	Children's glasses	Lenses: $15 copay; frames: no charge up to $130, then 100%.	Lenses: 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; deductible does not apply; dental deductible does not apply.	No charge up to allowed amount, then 100%; deductible does not apply; dental deductible 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 excluded services.)

- 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 deductible** **$500**
- **Specialist copayment** **$40 + 20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$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 deductible** **$500**
- **Specialist copayment** **$40 + 20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$390
Coinsurance	$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 deductible** **$500**
- **Specialist copayment** **$40 + 20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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**

In this example, Mia would pay:

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

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