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, please call 225-927-6340. 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.healthcare.gov/sbc-glossary or call 225-927-6340 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500**/person in- and out-of-network combined (may use HRA account to offset). Doesn't apply to Additional Accident Expense Benefit or preventive care/ screening/immunizations,	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.
Are there services covered before you meet your deductible?	Yes. Preventive care/ screening/immunizations and Additional Accident Expense Benefit 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** individual / **$5,000** family in- and out-of-network combined.	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 (unless balanced billing is prohibited), and, health care this plan doesn't cover,	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers go to www.bcbsil.com/providers or call 1-(800) 810-2583; For Pharmacy benefits call SavRx 1-(866) 233-4239.	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	30% Coinsurance	50% Coinsurance	None
	Specialist visit	30% Coinsurance	50% Coinsurance	None
	Preventive care/ screening/immunization	No charge	Not covered	For a list of covered preventive services see: https://www.healthcare.gov/coverage/preventive-care-benefits/. 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)	30% Coinsurance	50% Coinsurance	Some diagnostic tests may require preauthorization; failure to obtain when required results in initial denial of benefits/no medical necessity presumed.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	Some imaging may require preauthorization; failure to obtain when required results in initial denial of benefits/no medical necessity presumed.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at SavRx 1-866-233-4239 or www.savrx.com	Generic drugs	25% Coinsurance	Not covered	No charge for ACA-required generic preventive medications (e.g., FDA-approved generic contraceptives) or brand name contraceptives if a generic is not medically appropriate.
	Preferred brand drugs	25% Coinsurance	Not covered	
	Non-preferred brand drugs	25% Coinsurance	Not covered	
	Specialty drugs	25% Coinsurance	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Preauthorization is required; failure to obtain results in initial denial of benefits/no medical necessity presumed..

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)	
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	Preauthorization is required; failure to obtain results in initial denial of benefits/no medical necessity presumed.
If you need immediate medical attention	Emergency room care	30% Coinsurance	30% Coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	30% Coinsurance	30% Coinsurance for air ambulance services; 50% Coinsurance for other forms of emergency medical transportation	None
	Urgent care	30% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Average semi-private room rate. Preauthorization is required; failure to obtain results in initial denial of benefits/no medical necessity presumed.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% Coinsurance	50% Coinsurance	None.
	Inpatient services	30% Coinsurance	50% Coinsurance	Preauthorization required; failure to obtain results in initial denial of benefits/no medical necessity presumed.

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 are pregnant	Office visits	30% Coinsurance	50% Coinsurance	Pregnancy of dependent child not covered except for ACA-required prenatal screenings.
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	Delivery charges of dependent child not covered.
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	Delivery charges of dependent child not covered. Authorization required for stays exceeding 48 hours for vaginal delivery and 96 hours for caesarean section; failure to obtain results in denial of benefits for extended stay/no medical necessity presumed.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	Preauthorization required; failure to obtain results in initial denial of benefits/no medical necessity presumed.
	Rehabilitation services	30% Coinsurance	50% Coinsurance	Physical & Occupational Therapy each limited to 30 visits per person per calendar year. Speech Therapy limited to 20 visits per person per calendar year. Preauthorization required; failure to obtain results in initial denial of benefits/no medical necessity presumed..
	Habilitation services	30% Coinsurance	50% Coinsurance	Physical & Occupational Therapy each limited to 30 visits per person per calendar year. Speech Therapy limited to 20 visits per person per calendar year. Preauthorization required; failure to obtain results in initial denial of benefits/no medical necessity presumed.
	Skilled nursing care	30% Coinsurance	50% Coinsurance	120 days of confinement per 12-month period; room & board limited to 50% of semi-private rate. Preauthorization required; failure to obtain results in initial denial of benefits/no medical necessity presumed
	Durable medical equipment	30% Coinsurance	50% Coinsurance	None
	Hospice services	30% Coinsurance	50% 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 your child needs dental or eye care	Children's eye exam	Covered	Covered	Coverage limited to one routine exam/year.
	Children's glasses	Covered	Covered	Coverage limited to one pair of glasses or contact lenses per year.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

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
- Cellular Immunotherapy
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Gender-affirming care
- Gene Therapy
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (except as required by the ACA)

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

- Bariatric surgery (limited to $35,000/surgery, once every 10 years; prior approval required & must satisfy specific conditions)
- Chiropractic care (20 visits/calendar year)
- Infertility treatment ($500/couple; Lifetime Max.)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 225-927-6340, or 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 225-927-6340.

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** **$1,500**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$1,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,500**

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

- **The plan's overall deductible** **$1,500**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$1,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500**

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

- **The plan's overall deductible** **$1,500**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$1,500
Copayments	$0
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,890**

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