
 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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-309-764-8080. 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](http://www.dol.gov/ebsa/healthreform) or call 1-309-764-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For PPO: <b>\$600</b> Individual/ <b>\$1,500</b> Family For Non-PPO: <b>\$700</b> Individual/ <b>\$2,100</b> Family	Generally, you must pay all of the costs from providers 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. <u>Preventive care</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes, \$50 for emergency room services (waived if admitted).	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For PPO: <b>\$1,600</b> Individual/ <b>\$4,300</b> Family. For Non-PPO: <b>\$1,850</b> Individual/ <b>\$5,800</b> Family	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>Co-payments</u> , <u>premiums</u> , preauthorization penalty charges, prescriptions, dental and vision claims, <u>balance-billed charges</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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or refer to the toll free number on the back of your ID card for a list of participating providers. (Applies to Medical Benefits only)	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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 permission from this <u>plan</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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	15% coinsurance	20% coinsurance	Deductible applies
	<a href="#">Specialist</a> visit	15% coinsurance	20% coinsurance	Deductible applies
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% coinsurance for mammograms; subject to deductible	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% coinsurance for medical diagnosis. No charge for preventive.	20% coinsurance for medical diagnosis. No charge for preventive.	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	20% coinsurance	Pre-certification is required for oncology-related PET, CT/MRIs and of the heart.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> by contacting customer service at the phone number listed on your pharmacy ID card.	Generic drugs	\$10 copay/30-day retail prescription \$25 copay/90-day Performance 90 retail Network & Mail Order prescriptions.		<u>Deductible</u> & <u>Out-of-Pocket Max</u> do not apply to Rx.
	Preferred brand drugs			<u>Deductible</u> & <u>Out-of-Pocket Max</u> do not apply to Rx. If participant elects brand name when generic is available, will pay brand copay + cost difference between brand and generic drug.
	Non-preferred brand drugs	\$40 copay/30-day retail prescription \$60 copay/90-day Performance 90 Retail Network & Mail Order prescriptions.		
	<a href="#">Specialty drugs</a>			<u>Pre-authorization</u> required through Pharmacy Benefit Manager.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Refer to Plan Document for those out-patient procedures which require pre-certification.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% coinsurance	20% coinsurance	Subject to additional \$50.00 deductible; waived if admitted from the Emergency Room.
	<a href="#">Emergency medical transportation</a>	15% coinsurance	20% coinsurance	None
	<a href="#">Urgent care</a>	15% coinsurance	20% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	<u>Preauthorization</u> must be obtained from Utilization Review Vendor 7 days prior to non-ER inpatient admission or within 48 hours after

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)	
				admission. \$100 penalty assessed for unauthorized confinements.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	15% coinsurance	20% coinsurance	Court-ordered treatment not covered. Must be seen by MD, DO or PhD. Certified Mental Health Counselor & Social Worker with a master's degree can treat if they are practicing within the scope of their certification or license. Precertification with UR required for inpatient & partial inpatient admissions. \$100 penalty assessed for unauthorized confinements.
	Inpatient services	10% coinsurance	20% coinsurance	
<b>If you are pregnant</b>	Office visits	15% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	<u>Preauthorization</u> must be obtained from Utilization Review Vendor 7 days prior to non-ER inpatient admission or within 48 hours after admission. \$100 penalty assessed for unauthorized confinements.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% coinsurance	20% coinsurance	Limited to 100 visits per Calendar Year. 4 hr. max/day.
	<a href="#">Rehabilitation services</a>	15% coinsurance	20% coinsurance	Must be provided by licensed occupational or physical therapist to improve a body function. Pre-certification is required after 12 visits.
	<a href="#">Habilitation services</a>	15% coinsurance	20% coinsurance	Must be provided by certified Speech Therapist. Services for remedial, educational or initial development of natural speech are excluded. Pre-certification is required after 12 visits
	<a href="#">Skilled nursing care</a>	15% coinsurance	20% coinsurance	Limited to 120 days per Calendar year.
	<a href="#">Durable medical equipment</a>	15% coinsurance	20% coinsurance	Must pre-notify UR Vendor of any item which costs \$1,000 or more to rent or purchase.
	<a href="#">Hospice services</a>	15% coinsurance	20% coinsurance	Limited to Terminally Ill patients with fewer than 6 months to live.

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	No Charge	\$200 Reimbursement	Benefits available every 2 Calendar years. See <a href="http://www.vsp.com">www.vsp.com</a> for participating providers.
	Children's glasses	Most commonly prescribed lenses covered in full. Frames covered up to \$175 plus 20% off any out-of-pocket expense		
	Children's dental check-up	20% coinsurance		

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery (unless from accident injuries or for mastectomy)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Custodial Care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Spinal Manipulations (\$1200 calendar year max)</li> <li>Dental care, if elected (19 and over - \$2,500 per calendar year max)</li> <li>Certain Over-the-Counter Medication (\$5 copay)</li> </ul>	<ul style="list-style-type: none"> <li>Orthodontic Care (50% to \$2,000 lifetime limit – no age limit)</li> <li>Hearing aids (\$2,400 limit every 3 calendar years)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (adult)</li> <li>Bariatric Surgery (\$40,000 Lifetime max)</li> <li>Temporomandibular Joint Syndrome</li> </ul>

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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](http://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 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 1-800-764-8080.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ <a href="#">Other coinsurance</a>	15%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$1000
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,600</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ <a href="#">Other coinsurance</a>	15%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments (Rx only)	\$200
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a>	15%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ <a href="#">Other coinsurance</a>	15%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$50
Coinsurance	\$240
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$890</b>