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 or call 1-309-764-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For PPO: **$650** Individual/**$1,500** Family For Non-PPO: **$800** Individual/ **$2,500** 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. Preventive care 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 coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	Yes, **$80** for emergency room services (waived if admitted).	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For PPO: **$1,800** Individual/ **$4,800** Family. For Non-PPO: **$2,000** Individual/**$6,200** Family	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?	Co-payments, premiums, preauthorization penalty charges, prescriptions, dental and vision claims, balance-billed charges 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. See www.bcbsil.com 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 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 permission from this plan.

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	15% coinsurance	20% coinsurance	Deductible applies
	Specialist visit	15% coinsurance	20% coinsurance	Deductible applies
	Preventive care/screening/ immunization	No charge	20% coinsurance for mammograms; subject to deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (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.
If you need drugs to treat your illness or condition More information about prescription drug coverage by contacting customer service at the phone number listed on your pharmacy ID card.	Generic drugs	$15 copay/30-day retail prescription $30 copay/90-day Performance 90 retail Network & Mail Order prescriptions.		Deductible & Out-of-Pocket Max do not apply to Rx.
	Preferred brand drugs	$50 copay/30-day retail prescription $75 copay/90-day Performance 90 Retail Network & Mail Order prescriptions.		Deductible & Out-of-Pocket Max 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			
	Specialty drugs			Pre-authorization required through Pharmacy Benefit Manager.
If you have outpatient surgery	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	
If you need immediate medical attention	Emergency room care	10% coinsurance	20% coinsurance	Subject to additional $80.00 deductible; waived if admitted from the Emergency Room.
	Emergency medical transportation	15% coinsurance	20% coinsurance	None
	Urgent care	15% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Preauthorization 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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	20% coinsurance	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	
If you are pregnant	Office visits	15% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Preauthorization 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.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance	Limited to 100 visits per Calendar Year. 4 hr. max/day. Pre-Certification/Non-Compliance Penalty - $100 Co-Pay for Non-Compliance
	Rehabilitation services	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.
	Habilitation services	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
	Skilled nursing care	15% coinsurance	20% coinsurance	Limited to 120 days per Calendar year.
	Durable medical equipment	15% coinsurance	20% coinsurance	Must pre-notify UR Vendor of any item which costs $1,000 or more to rent or purchase.

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)	
	Hospice services	15% coinsurance	20% coinsurance	Limited to Terminally Ill patients with fewer than 6 months to live.
If your child needs dental or eye care	Children's eye exam	No Charge	$200 Reimbursement	Vision Exams are covered in full every Calendar Year. All other vision benefits (Glasses, Frames and Contacts) available every 2 Calendar years. See www.vsp.com 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		No limit for ages 12 and under.

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
- Cosmetic Surgery (unless from accident injuries or for mastectomy)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine foot care
- Custodial Care
- Weight loss programs

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

- Spinal Manipulations ($1,500 calendar year max)
- Dental care, if elected (19 and over - $2,500 per calendar year max)
- Certain Over-the-Counter Medication ($5 copay)
- Orthodontic Care (50% to $2,000 lifetime limit – no age limit)
- Hearing aids ($2,400 limit every 3 calendar years)
- Routine eye care (adult)
- Bariatric Surgery ($40,000 Lifetime max)
- Temporomandibular Joint Syndrome

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 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, kwiijigo 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 plan's overall deductible	$650
Specialist	15%
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$650
Copayments	$0
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,650**

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

The plan's overall deductible	$650
Specialist	15%
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$650
Copayments (Rx only)	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,650**

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

The plan's overall deductible	$650
Specialist	15%
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$650
Copayments	$80
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$970**

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