



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 1-800-435-5694 or visit us at www.pbaclaims.com. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: \$1,250 Individual / \$2,500 family Non-PPO: \$2,500 Individual / \$5,000 family <u>Copayments</u> don't apply to the <u>deductible</u> .	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 deductible?	Yes. PPO preventive care, services subject to copays (unless otherwise stated), and prescription drugs.	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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	PPO: \$4,000 Individual / \$8,000 family Non-PPO: \$8,000 Individual / \$16,000 family Prescription Drugs: \$1,000 Individual / \$2,000 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 plan, they have to meet their own <u>out-of-pocket limit</u> until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Non-compliance penalties, <u>premiums</u> , <u>balance-billing</u> charges, 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 network provider?	Yes. For a list of PPO providers see www.bcbsil.com or call (800) 810-2583	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 referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a referral.

Housing: Employee Health Plan (Value PPO)



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
		PPO Provider (You'll pay the least)	Non-PPO Provider (You'll pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit (no deductible) 20% <u>coinsurance</u> for allergy testing, injections and serum.	40% <u>coinsurance</u>	—————none—————
	<u>Specialist</u> visit			
	Chiropractic services	\$35 copay/visit (no deductible)	40% <u>coinsurance</u>	20-visit annual max
	<u>Preventive care/screening/immunization</u>	No charge (no deductible)	40% <u>coinsurance</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Optumrx.com (855) 312-7412	Generic drugs	\$10 copay + 25% / prescription - \$25 max (retail) \$20 copay / prescription (mail order)		Limits: 30-day supply (retail); 90-day supply (mail order) Cost sharing does not apply to certain preventive services.
	Preferred brand drugs	\$35 copay + 25% / prescription - \$70 max (retail) \$70 copay / prescription (mail order)		
	Non-preferred brand drugs	\$50 copay + 25% / prescription - \$100 max (retail) \$100 copay / prescription (mail order)		
	<u>Specialty drugs</u>	Retail copays		Limits: 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	\$150 copay, <u>deductible</u> , and 20% <u>coinsurance</u> after	Same as PPO	Copay waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<u>Urgent care</u>	\$50 copay/visit (no deductible)	40% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. The non-compliance penalty is \$250.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————

Housing: Employee Health Plan (Value PPO)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You'll pay the least)	Non-PPO Provider (You'll pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office visits	\$35 copay/visit (no deductible)	40% coinsurance	—————none—————
	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	<u>Preauthorization</u> is required. The non-compliance penalty is \$250.
If you are pregnant	Office visits	\$35 copay/visit (no deductible)	40% coinsurance	<u>Cost sharing</u> does not apply to certain preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	—————none—————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	<u>Preauthorization</u> may be required. The non-compliance penalty is \$250.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance	40% coinsurance	20-visit annual max
	<u>Rehabilitation services</u>	20% coinsurance	40% coinsurance	20-visit annual max
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	20% coinsurance	40% coinsurance	Skilled nursing facility: 60-day annual max
	<u>Durable medical equipment</u>	20% coinsurance	40% coinsurance	—————none—————
	<u>Hospice services</u>	20% coinsurance	40% coinsurance	—————none—————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Housing: Employee Health Plan (Value PPO)

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694. 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.**

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 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 **1-800-435-5694**.

—————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 <u>plan's overall deductible</u>	\$1,250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1250
<u>Copayments</u>	\$180
<u>Coinsurance</u>	\$2060
<i>What isn't covered</i>	
Limits or exclusions	\$210
The total Peg would pay is	\$3700

Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$1,250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$1280
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$1670

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$1,250
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1250
<u>Copayments</u>	\$220
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1500

Please note: These coverage examples are based on self-only coverage. The "Having a Baby" example includes charges for the baby. These charges are not considered under the mother, but would be considered under the baby.