Housing: Employee Health Plan (Value PPO w/Premier Drug)

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 Copayments don't apply to the deductible.	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. PPO preventive care, services subject to copays (unless otherwise stated), and prescription drugs.	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?	PPO: **$4,000** Individual / **$8,000** family Non-PPO: **$8,000** Individual / **$16,000** family Prescription Drugs: **$1,000** Individual / **$2,000** 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Non-compliance penalties, premiums, balance-billing 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. For a list of PPO providers see www.bcbsil.com or call (800) 810-2583	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.

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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% coinsurance for allergy testing, injections and serum.	40% coinsurance	————none————
	Specialist visit			
	Chiropractic services	$35 copay/visit (no deductible)	40% coinsurance	20-visit annual max
	Preventive care/screening/ immunization	No charge (no deductible)	40% coinsurance	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	40% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	————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/prescription 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/prescription retail $70 copay/prescription mail order		
	Non-preferred brand drugs	$50 copay/prescription retail $100 copay/prescription mail order		
	Specialty drugs	Retail copays		Limits: 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————none————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————none————
If you need immediate medical attention	Emergency room care	$150 copay, deductible, and 20% coinsurance after	Same as PPO	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	————none————
	Urgent care	$50 copay/visit (no deductible)	40% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. The non-compliance penalty is $250.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————none————

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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	Preauthorization is required. The non-compliance penalty is $250.
If you are pregnant	Office visits	$35 copay/visit (no deductible)	40% coinsurance	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	————none————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Preauthorization may be required. The non-compliance penalty is $250.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	20-visit annual max
	Rehabilitation services	20% coinsurance	40% coinsurance	20-visit annual max
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing facility: 60-day annual max
	Durable medical equipment	20% coinsurance	40% coinsurance	————none————
	Hospice services	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

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	• Hearing aids	• Private-duty nursing
• Dental care	• Infertility treatment	• Routine eye care
• Habilitation services	• Long-term care	• Routine foot care
	• Non-emergency care when traveling outside the U.S.	• 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 plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$35**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1250
Copayments	$180
Coinsurance	$2060
What isn't covered	
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 plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$35**
■ **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1280
Coinsurance	$0
What isn't covered	
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 plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$35**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1250
Copayments	$220
Coinsurance	$30
What isn't covered	
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.

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