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, visit www.smw91.org or call 1-309-787-0695 ext.118. For general definitions of common terms, such as allowed amount, coinsurance, copayment, deductible, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-309-787-0695 ext.118 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** Individual/**$900** 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. Well-child care, in-network preventive care.	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.
Are there other deductibles for specific services?	Yes, **$100** for emergency room services (waived if admitted). **$100** person/**$300** family for dental. There are no other specific deductibles.	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?	**$2,000**/person for In-Network and **$4,000**/person for Out-of-Network.	The out-of-pocket limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, copayments, deductibles 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.	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	20% coinsurance.	30% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.
	Specialist visit	20% coinsurance	30% coinsurance	Applies to Non-PCP providers.
	Others practitioner office visit	$5/procedure for chiropractic therapies; $25/visit for chiropractic spinal manipulations; $40 for chiropractic exams		Chiropractic exams limited to two per calendar year. Limited to a calendar year maximum of 24 adjustments.
	Preventive care/screening/ immunization	No charge	No charge	Limited to 1 exam per year for age 19 and over. Refer to Plan document for specific charges for screenings.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	20% coinsurance (retail); $20/prescription (mail order)		None
	Brand name drugs	40$ coinsurance (retail); $60/prescription (mail order)		Dispense as written for 30-day supply = 20% plus the difference in cost between Generic and Brand name Drugs unless Physician indicates medical necessity.
	Non-preferred brand name drugs			
	Specialty drugs	10% or $150 maximum coinsurance		First fill is at retail; directed to Specialty Pharmacy for subsequent fills.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	$100 deductible per visit; waived if admitted as in-patient.
	Emergency medical transportation	20% coinsurance	30% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Authorization must be obtained from Utilization Review Vendor prior to non-ER inpatient admission or within 48 hours after admission.

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)	
				Penalty will be lesser of actual benefits under Plan or $500.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Must be seen by MD, DO, PhD, PA. NP, MSW. LCSW, LCPC, or LMFT,
	Inpatient services	20% coinsurance	30% coinsurance	Must be seen by MD, DO, PhD, PA, NP, MSW LCSW, LCPC or LMFT. Authorization must be obtained from Utilization Review Vendor prior to non-ER inpatient admission or within 48 hours after admission. Penalty will be lesser of actual benefits under Plan or $500
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Authorization must be obtained from Utilization Review Vendor for a vaginal delivery stay longer than 48 hours after admission or a cesarean section stay longer than 96 hours. Penalty will be lesser of actual benefits under Plan or $500.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	See Limitations		Must begin within 14 days from hospital/skilled nursing facility release. The max per day is $150 and the max per year is $7,500.
	Rehabilitation services	20% coinsurance	30% coinsurance	Occupational therapy covered only to restore a physical function.
	Habilitation services	20% coinsurance	30% coinsurance	Speech therapy covered because of a physical impairment caused by disease or injury. Speech therapy allowed for children up to age 19 if medically necessary and child has received diagnosis of developmental delay.

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)	
	Skilled nursing care	20% coinsurance	30% coinsurance	Not to exceed 60 days per calendar year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Not to exceed purchase price
	Hospice services	20% coinsurance	30% coinsurance	Limited to a 6-month period however can be recertified. 12 month total limit. Hospice at home is limited to 120 hours during each consecutive 3-month period.
If your child needs dental or eye care	Children's eye exam	No charge		Limited to one exam per year with no dollar limits up to age 18.
	Children's glasses	No charge		Limited to 1 per calendar year (glasses or contacts).
	Children's dental check-up	No charge		Orthodontics is limited to a $2,000 lifetime limit. See Plan for details.

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
- Bariatric surgery
- Cosmetic surgery (unless from accident injuries of mastectomy)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Dental care (Adult) ($1,500 per calendar year)
- Hearing aids (1 exam per 3 year period, and $4,000 for device(s) per 3 year period)
- Routine eye care (Adult)

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 1-309-787-0695 ext. 118.

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 309-787-0695 ext. 118
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 309-787-0695- ext.118
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 309-787-0695 ext. 118
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 309-787-0695 ext. 118

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	$300
Specialist	20%
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	$300
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,300**

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

The plan's overall deductible	$300
Specialist	20%
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	$300
Copayments (Rx only)	$320
Coinsurance	$1,004
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,704**

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

The plan's overall deductible	$300
Specialist	20%
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	$300
Copayments	$0
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

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