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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, contact AHR at 1-800-570-3757. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-800-570-3757 to request a copy. |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **In Network: $2,500 single, $5,000 EE+ or Family****Out of Network: $14,000 single, $28,000 EE+ or 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, the plan will begin to pay for a family member once they meet their own individual deductible. It will also pay if the total amount of deductible expenses paid by all family members meets the overall family deductible.The LAYERED PLAN covers $4,500 of the individual deductible and $9,000 of the employee plus spouse, children or family deductible of your major medical plan. Only those charges allowable by your major medical plan are allowable by your LAYERED PLAN.  |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **Yes. Office visits, prescriptions and urgent care, subject to the copays listed below.** |

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| 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. |

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| **Are there other**[**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | **No** |

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| You don’t have to meet deductibles for specific services  |

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| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | **In Network: $4,000 single, $8,000 EE+ or Family****Out of Network: $14,000 single, $45,000 EE+ or 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.The LAYERED PLAN covers $3,000 of the individual out of pocket maximum and $7,000 of the employee plus spouse, children or family out of pocket maximum of your major medical plan. Only those charges allowable by your major medical plan are allowable by your LAYERED PLAN.  |
| **What is not included in****the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | **Expenses not allowed by your major medical policy** | Your out of pocket expenses may be substantially higher if you go out of network for your care, or if your major medical insurer denies coverage of your medical care. |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | **Yes** | 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. Please refer to the Summary of Benefits and Coverage provided by your major medical insurer for details about out of network coverage limitations |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | **No** | You can see the specialist you choose without a referral |

|  | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $20 | Ded. Then 50% | See major medical plan |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) ,PT Visit | $20 | Ded. Then 50% | See major medical plan |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization | $0 | Ded. Then 50% | See major medical plan |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| Imaging (CT/PET scans, MRIs)  | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If you need drugs to treat your illness or condition**More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.bcbsil.com](http://www.bcbsil.com) | Generic drugs | $10  |  | See major medical plan |
| Preferred brand drugs | $35 |  | See major medical plan |
| Non-preferred brand drugs | $60 |  | See major medical plan |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug)  | $150 |  | See major medical plan |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| Physician/surgeon fees | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $150 |  | See major medical plan **Many additional exclusions may apply if you could have obtained care at an Urgent Care facility** |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $50 | Ded. Then 50% | See major medical plan |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| Physician/surgeon fees | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| Inpatient services | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If you are pregnant** | Office visits | $20 | Ded. Then 50% | See major medical plan |
| Childbirth/delivery professional services | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| Childbirth/delivery facility services | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20%, after your deductible is met | Ded. Then 50% | See major medical plan |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | Not covered | See major medical plan |
| Children’s glasses | Not covered | Not covered | See major medical plan |
| Children’s dental check-up | Not covered | Not covered | See major medical plan |

**Excluded Services & Other Covered Services:**

|  |
| --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
| Services not covered by your major medical policy |  |  |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** |
| N/A |  |  |

**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](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

**Does this plan provide Minimum Essential Coverage? [Yes]**

If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al [630-762-1717.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [N/A.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [N/A]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [N/A]

––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––*–––––––––––

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $20**

◼ **Hospital (facility) *[cost sharing]* 0%**

◼ **Other** ***[cost sharing]* 0%**

**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 | $2,500 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,000** |

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $20**

◼ **Hospital (facility) *[cost sharing]* 0%**

◼ **Other *[cost sharing]* 0%**

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

**In this example, Joe would pay:**

|  |
| --- |
| *Cost Sharing* |
| Deductibles | $2,500 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,000** |

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* $20**

◼ **Hospital (facility) *[cost sharing]* 0%**

◼ **Other *[cost sharing]* 0%**

**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 | $700 |
| Copayments | $120 |
| Coinsurance | $0 |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$820** |