**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 1-866-844-0488. 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 1-866-844-0488 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$500** per person/**$1,000** per family; Non-Network: **$800** per person/**$1,600** per 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. Hearing aids and in-Network preventive services and physical exams, 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 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?** | Yes. **$50** per person/**$100** per family for non-generic prescription drugs. No other specific deductibles apply to medical/drug benefits (this SBC is n/a to dental/vision). | 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?** | Network: **$3,500** per person/**$7,000** per family; Prescription Drugs: **$3,000** per person/**$6,000** per family; Non-Network**: $5,600** per person/**$11,200** per 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?** | Premiums, balance-billing charges, penalties for failure to obtain preauthorization (called pre-certification deductibles) or provide required notice after ER visit, expenses above any plan limit, chiropractic care, acupuncture, non-surgical TMJ, certain podiatry expenses, dental and vision expenses (which are not part of the medical benefits), ), prescription drugs (subject to separate limits), certain specialty pharmacy drugs that are considered non-essential health benefits and fall outside the out-of-pocket limits, and any services this plan does not 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 call 1-800-810-2583 for a list of network 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 a referral. |

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) | Non-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 | 25% coinsurance | 40% coinsurance | None |
| | Specialist visit | 25% coinsurance | 40% coinsurance | You pay 50% for chiropractic, acupuncture and non-surgical temporomandibular (TMJ) treatment; plan pays up to $1,000 per person per year for all expenses combined (network and non-network combined).<br>You pay 50% for podiatry expenses. Plan pays up to $1,000 per person per year for podiatry services (network and non-network combined); limit does not apply to podiatry expenses for removal of nail roots or for care prescribed by a physician treating metabolic or peripheral vascular disease. |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | 40% coinsurance | 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) | 25% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs | 20% coinsurance with a $10 minimum for retail; 20% coinsurance with a $20 minimum and $40 maximum for mail order. | Not covered | The medical deductible and out-of-pocket limit do not apply to prescription drugs. There is a separate $50 per person/$100 per family deductible for non-generic prescription drugs. There is a separate out-of-pocket limit for covered prescription drugs.<br><br>You may obtain up to a 30-day supply at retail or a 90-day supply at network retail pharmacies or through mail order. After an initial fill at retail and one refill, you must either use a network retail pharmacy or use the mail order program for maintenance medications.<br><br>No charge for FDA-approved generic contraceptives or other ACA-required preventive drugs. Brand drugs are covered at no charge if a generic equivalent is medically inappropriate.<br><br>Prior authorization and step therapy applies to some prescription drugs. |
| | Preferred brand drugs | 20% coinsurance with a $25 minimum for retail; 20% coinsurance with a $50 minimum and $150 maximum for mail order plus the difference between generic and brand name drug when doctor allows substitution. | Not covered | |
| | Non-preferred brand drugs | 20% coinsurance with a $40 minimum for retail; 20% coinsurance with an $80 minimum and $250 maximum for mail order plus the difference between generic and brand name drug when doctor allows substitution. | Not covered | |
| | Specialty drugs | 20% coinsurance with a $100 minimum and a $250 maximum. | Not covered | Certain medications may be obtained only through the CVS Caremark Specialty Pharmacy. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | Not covered | $250 non-preauthorization deductible if you don't call to preauthorize with Valenz at 1-800-845-7348. |
| | Physician/surgeon fees | 25% coinsurance | Not covered | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance for emergency medical condition; otherwise, 50% coinsurance | 25% coinsurance for emergency medical condition; otherwise, 50% coinsurance | Network deductible and out-of-pocket limit apply to non-network emergency room care for emergency medical condition. |
| | Emergency medical transportation | 25% coinsurance for ground and air ambulance | 40% coinsurance for ground and 25% coinsurance for air ambulance | Air ambulance services are covered only when the plan determines they are medically necessary. Preauthorization by Valenz (1-800-845-7348) is required for non-emergency air ambulance services or coverage will be denied. |
| | Urgent care | 25% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate. |
| | Physician/surgeon fees | 25% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 25% coinsurance | 40% coinsurance | None |
| | Inpatient services | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate. |
| **If you are pregnant** | Office visits | 25% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 25% coinsurance | 40% coinsurance | Coverage based on semi-private room rate. |
| | Childbirth/delivery facility services | 25% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| | Rehabilitation services | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| | Habilitation services | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| | Skilled nursing care | 25% coinsurance | 40% coinsurance | Up to 90 days per person per year (network and non-network combined); $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| | Durable medical equipment | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz at 1-800-845-7348 to preauthorize purchase over $500 or rental. Plan pays up to $10,000 per person per year for benefits that are not essential health benefits under ACA. Plan pays up to $25,000 per prosthesis every 5 years. |
| | Hospice services | 25% coinsurance | 40% coinsurance | $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. |
| **If your child needs dental or eye care** | Children's eye exam | Based on schedule. Medical deductible does not apply. | Not covered | Separately insured by EyeMed (not part of medical benefit). Must use EyeMed provider; exam/glasses up to once every 12-month period. |
| | Children's glasses | Discounts only. Medical Deductible listed does not apply. | Not covered | |
| | Children's dental check-up | Based on schedule. Medical deductible does not apply. | Based on schedule. Medical deductible does not apply. | Separately administered by Delta Dental (not part of medical benefit). No deductible applicable to preventive/diagnostic care, including check-ups. ($3,000 annual maximum). |

## 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.)**

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by ACA)

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

- Acupuncture (50% coinsurance)
- Bariatric surgery (Limited to once per person per lifetime, preauthorization required and excludes dependent children)
- Chiropractic care (50% coinsurance)
- Hearing aids (up to $1,000 per person in 3-year period, $500 per ear)
- Non-emergency care when traveling outside the U.S. (paid as out-of-network with $250 non preauthorization deductible)
- Routine foot care (50% coinsurance)

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: the Fund Office at 1-866-844-0488. 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. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-527-9431 or DOI.Director@Illinois.gov.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 1-866-844-0488.

*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 in-Network coverage.

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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** | **$12,700** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $0 |
| Coinsurance | $3,035 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,595** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $550* |
| Copayments | $100 |
| Coinsurance | $1,180 |
| *What isn't covered* | |
| Limits or exclusions | $230 |
| **The total Joe would pay is** | **2,060** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $0 |
| Coinsurance | $575 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,075** |

***NOTE:** This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. The **plan** would be responsible for the other costs of these EXAMPLE covered services.