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: **$100** per person/**$200** per family; Non-Network: **$200** per person/**$400** 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 office visits with UHS 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 (SBC 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: **$1,100** per person/**$2,200** per family; Prescription Drugs: **$3,000** per person/**$6,000** per family; Non-Network**: $2,200** per person/**$4,400** 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 medical benefits),, prescription drugs (subject to separate limit), 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 or see a UHS provider. 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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[1]
		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	No charge at UHS and deductible does not apply; 10% coinsurance with referral for non-UHS	20% coinsurance if UHS referral	No coverage if you see a provider outside of UHS unless you have a referral from UHS.
	Specialist visit	No charge at UHS and deductible does not apply; 10% coinsurance with referral for non-UHS	20% coinsurance with UHS referral	You pay 50% for non-UHS chiropractic, acupuncture and non-surgical temporomandibular (TMJ) treatment (no coverage if not at UHS or no referral) ; plan pays up to $1,000 per person per year for all expenses combined (network and non-network combined). You pay 50% coinsurance for podiatry expenses with UHS referral (no coverage if not at UHS and no referral). 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 at UHS. Deductible does not apply.	Not covered	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)	No charge at UHS; 10% coinsurance with referral for non-UHS	20% coinsurance with UHS referral	No coverage if not performed at or upon referral from UHS.

[1] Unless otherwise provided, a UHS referral is required for all services provided outside of UHS.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge at UHS; 10% coinsurance with referral for non-UHS	20% coinsurance with UHS referral	No coverage if not performed at or upon referral from UHS.
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. 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. 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. 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance with UHS referral	Not covered	$250 non-preauthorization deductible if you don't call to preauthorize with Valenz at 1-800-845-7348.
	Physician/ surgeon fees	10% coinsurance with UHS referral	Not covered	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance for emergency medical condition; otherwise, 50% coinsurance	10% coinsurance for emergency medical condition; otherwise, 50% coinsurance	No coverage if you don't notify UHS (1-312-423-4200) and $250 penalty if you don't notify Valenz (1-800-845-7348) within 48 hours of the visit. Network deductible and out-of-pocket limit apply to non-network emergency room care for emergency medical condition.
	Emergency medical transportation	10% coinsurance with UHS referral for ground and air ambulance	20% coinsurance with UHS referral for ground and 10% coinsurance with UHS referral for air ambulance	Air ambulance services are covered only when the plan determines they are medically necessary. Preauthorization by Valenz (1-800-845-7348) and UHS (1-312-423-4000) is required for non-emergency air ambulance services or coverage will be denied.
	Urgent care	10% coinsurance with UHS referral	20% coinsurance with UHS referral; coinsurance to treat an emergency medical condition	No coverage if you don't notify UHS (312-423-4200) in advance if it's not an emergency medical condition and within 48 hours if it is.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$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	10% coinsurance with UHS referral	20% coinsurance with UHS referral	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge at UHS and deductible does not apply; 10% coinsurance for non-UHS with UHS referral	20% coinsurance with UHS referral	No coverage if not performed at or upon referral from UHS.
	Inpatient services	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate. No coverage if not performed at or upon referral from UHS.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge with UHS; 10% coinsurance with UHS referral	20% coinsurance with UHS referral	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Prenatal care (other than ACA-required preventive screenings) not covered for dependent children.
	Childbirth/delivery professional services	No charge with UHS; 10% coinsurance with UHS referral	20% coinsurance with UHS referral	Coverage based on semi-private room rate. $250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348 if hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery facility services	No charge with UHS; 10% coinsurance with UHS referral	20% coinsurance with UHS referral	
If you need help recovering or have other special health needs	Home health care	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348.
	Rehabilitation services	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348.
	Habilitation services	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348.
	Skilled nursing care	10% coinsurance with UHS referral	20% coinsurance with UHS referral	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	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$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	10% coinsurance with UHS referral	20% coinsurance with UHS referral	$250 non-preauthorization deductible if you don't call Valenz to preauthorize at 1-800-845-7348.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
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. Must use EyeMed provider; exam/glasses up to once every 12-month period.
	Children's glasses	Discounts only. Medical deductible 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 applies to preventive/diagnostic care, including check-ups($3,000 annual maximum).

[1] Unless otherwise provided, a UHS referral is required for all services provided outside of UHS.

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 (except for standard fertility preservation services provided by UHS)
- 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 with UHS referral)
- Bariatric surgery (Limited to once per person per lifetime, preauthorization required and excludes dependent children)
- Chiropractic care (50% coinsurance with UHS referral)
- Hearing aids (up to $1,000 per person in a 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)
- Private-duty nursing
- Routine foot care (50% coinsurance with UHS referral)

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 coverage and in-network and/or UHS providers.

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

The plan's overall deductible	**$100**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$100
Copayments	$0
Coinsurance	$860
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$960**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$150*
Copayments	$100
Coinsurance	$412
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$892**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$100
Copayments	$0
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

***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.