
 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](http://www.dol.gov/ebsa/healthreform) or call 1-866-844-0488 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	Network: <b>\$100</b> per person/ <b>\$200</b> per family; Non-Network: <b>\$200</b> per person/ <b>\$400</b> per family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive services</u> , physical exams, <u>prescription drugs</u> , hearing aids, and dental and vision services are covered before you meet your <u>deductible</u> when you use a network provider.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. For Delta Dental: <b>\$25</b> per person/ <b>\$75</b> per family for PPO and <b>\$50</b> per person/ <b>\$75</b> per family for non-PPO, and <b>\$50</b> per person/ <b>\$100</b> per family for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Network: <b>\$1,100</b> per person/ <b>\$2,200</b> per family; Prescription Drugs: <b>\$3,000</b> per person/ <b>\$6,000</b> per family; Non-Network: <b>\$2,200</b> per person/ <b>\$4,400</b> per family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> (called pre-certification <u>deductibles</u> ) or provide required notice after ER visit, expenses above any <u>plan</u> limit, chiropractic care, acupuncture, non-surgical TMJ, certain podiatry expenses, dental and vision expenses (which are separately provided), <u>non-network cost sharing</u> (subject to separate limit), <u>prescription drugs</u> (subject to separate limit), certain specialty pharmacy drugs that are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u> , and any services this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	You pay 50% for chiropractic, acupuncture and non-surgical temporomandibular (TMJ) treatment; <u>plan</u> pays up to \$1,000 per person per year for all expenses combined ( <u>network</u> and <u>non-network</u> combined).
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.

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 a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	Generic drugs	20% <u>coinsurance</u> with a \$10 minimum for retail after \$50 <u>deductible</u> ; 20% <u>coinsurance</u> with a \$20 minimum and \$40 maximum for mail order.	Not covered	The medical <u>deductible</u> and <u>out-of-pocket limit</u> do not apply to <u>prescription drugs</u> . There is a separate \$50 per person/\$100 per family <u>deductible</u> for <u>prescription drugs</u> . There is a separate <u>out-of-pocket limit</u> for covered <u>prescription drugs</u> .
	Preferred brand drugs	20% <u>coinsurance</u> with a \$25 minimum for retail after \$50 <u>deductible</u> ; 20% <u>coinsurance</u> 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% <u>coinsurance</u> with a \$40 minimum for retail; 20% <u>coinsurance</u> 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	No charge for FDA-approved generic contraceptives or other ACA-required preventive drugs. Brand drugs are covered at no charge if a generic is medically inappropriate.  Step therapy applies to some <u>prescription drugs</u> .
	<u>Specialty drugs</u>	20% <u>coinsurance</u> 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)	10% <u>coinsurance</u>	Not covered	\$250 non- <u>preauthorization deductible</u> if you don't call to preauthorize with Valenz at 1-800-845-7348.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> for <u>emergency medical condition</u> ; otherwise, 50% <u>coinsurance</u>	10% <u>coinsurance</u> for <u>emergency medical condition</u> ; otherwise, 50% <u>coinsurance</u>	<u>Network deductible</u> and <u>non-network out-of-pocket limit</u> apply to <u>non-network emergency room care</u> for <u>emergency medical condition</u> .
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> for ground and air ambulance	20% <u>coinsurance</u> for ground and 10% <u>coinsurance</u> for air ambulance	Air ambulance services are covered only when the <u>plan</u> determines they are <u>medically necessary</u> . <u>Preauthorization</u> by Valenz (1-800-845-7348) is required for non-emergency air ambulance services or coverage will be denied.
	<u>Urgent care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> 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	10% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage based on semi-private room rate.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	

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	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to 90 days per person per year ( <u>network</u> and <u>non-network</u> combined); \$250 non- <u>preauthorization deductible</u> if you don't call Valenz to preauthorize at 1-800-845-7348.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> if you don't call Valenz at 1-800-845-7348 to preauthorize purchase over \$500 or rental. <u>Plan</u> pays up to \$10,000 per person per year for benefits that are not essential health benefits under ACA. <u>Plan</u> pays up to \$25,000 per prosthesis every 5 years.
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 non- <u>preauthorization deductible</u> 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. <u>Deductible</u> does not apply.	Not covered	Separately insured by EyeMed. Must use EyeMed <u>provider</u> ; exam/glasses up to once every 12-month period.
	Children's glasses	Discounts only. <u>Deductible</u> does not apply.	Not covered	
	Children's dental check-up	Based on schedule (after \$25 <u>deductible</u> for Delta Dental PPO <u>Plan</u> . Overall <u>deductible</u> does not apply.	Based on schedule (after \$50 <u>deductible</u> for Delta Dental non-PPO <u>Plan</u> . Overall <u>deductible</u> does not apply.	Separately provided by Delta Dental (\$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)
- Dental care (Adult)(Provided by Delta Dental; \$3,000 annual maximum)
- 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 eye care (Adult) (Provided by EyeMed, call 1-866-723-0514)
- 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](http://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](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 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](http://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](mailto: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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$110*
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,170</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150*
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,110
<i>What isn't covered</i>	
Limits or exclusions	\$230
<b>The total Joe would pay is</b>	<b>\$1,490</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$110*
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$380</b>

\*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.