**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 1-312-738-2811. 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 1-312-738-2811 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | PPO provider and Non-PPO provider combined: **$240** per person/**$720** 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. PPO provider Prescription Drugs, PPO provider Preventive Care, PPO provider physician and specialist office visits, Department of Transportation Required Exams and Tests, and vision care from a PPO provider are covered before you meet your deductible. | This plan covers some items and services even if you have not 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. **$125** per person 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?** | PPO provider: **$1,000** per person; **$3,000** per family; In-network prescription drugs: **$2,500** per person; **$5,000** 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?** | Non-PPO provider expenses (except for emergency care), premiums, balance-billing charges, penalties for failure to obtain preauthorization, and health care this plan doesn't cover. | Even though you pay these expenses, they do not 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 PPO 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 |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO 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 copay per visit. Deductible does not apply. | 35% coinsurance | None |
| | Specialist visit | $40 copay per visit. Deductible does not apply. | 35% coinsurance | None |
| | Preventive care/screening/ Immunization | No charge. Deductible does not apply. | Not covered | You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check with what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 35% coinsurance | Check to see if preauthorization is required or possibly pay a penalty of 50% of eligible charges. |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a penalty of 50% of eligible charges. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs | $5 copay per fill retail (34 days), $12.50 copay per fill retail (90 days), $12.50 copay per fill mail order (90 days). Deductible does not apply. | Not covered | Covers up to a 34-day supply (retail); up to a 90-day supply (retail or mail order).<br>If you choose a brand name drug when a generic is available, you will pay the higher copay plus the difference in cost between the generic and brand name medication.<br>No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).<br>Copays for diabetic drugs and testing supplies are reduced by 50% for those enrolled in the Plan's Diabetes Program. |
| | Preferred brand drugs | $25 copay per fill retail (34 days), $60 copay per fill retail (90 days), $60 copay per fill mail order (90 days). Deductible does not apply. | Not covered | |
| | Non-preferred brand drugs | $50 copay per fill retail (34 days), $125 copay per fill retail (90 days), $125 copay per fill mail order (90 days). Deductible does not apply. | Not covered | |
| | Specialty drugs | $75 copay per fill retail (34 days), $182.50 copay per fill retail (90 days), $182.50 copay per fill mail order (90 days). Deductible does not apply. | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a $600 penalty. |
| | Physician/surgeon fees | 15% coinsurance | 35% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 15% coinsurance | 15% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | 15% coinsurance | 15% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a $600 penalty.<br>Charges limited to semi-private room rates. |
| | Physician/surgeon fees | 15% coinsurance | 35% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay per office visit; deductible does not apply. 15% coinsurance for other outpatient services. | 35% coinsurance | None |
| | Inpatient services | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call MAP at 1-866-532-8652.<br>Failure to preauthorize will result in a $600 penalty.<br>Charges limited to semi-private room rates. |
| **If you are pregnant** | Office visits | No charge. Deductible does not apply. | 35% coinsurance | Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children.<br>Maternity care may include tests and services described somewhere else in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 15% coinsurance | 35% coinsurance | Failure to preauthorize stays exceeding 48 hours following a vaginal delivery and 96 hours following a cesarean section will result in a $600 penalty.<br>Delivery expenses are not covered for dependent children.<br>Charges limited to semi-private room rates. |
| | Childbirth/delivery facility services | 15% coinsurance | 35% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 35% coinsurance | 40 visits per calendar year.<br>Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a penalty of 50% of eligible charges. |
| | Rehabilitation services | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a penalty of 50% of eligible charges. |
| | Habilitation services | 15% coinsurance | 35% coinsurance | Coverage limited to speech therapy; plan does not cover habilitation services for physical or occupational therapy. |
| | Skilled nursing care | 15% coinsurance | 35% coinsurance | 90 days per calendar year.<br>Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a $600 penalty. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a penalty of 50% of eligible charges. |
| | Hospice services | 15% coinsurance | 35% coinsurance | Preauthorization is required. Must call Med-Care at 1-800-441-7705.<br>Failure to preauthorize will result in a $600 penalty. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge. Deductible does not apply. | Not covered | One exam per calendar year.<br>One pair of frames per calendar year (plan pays 100% of the discounted cost up to $300 per calendar year, and 50% of the discounted cost over $300, plus lenses); or annual supply contact lens or lenses.<br>$300 annual maximum does not apply to individuals under age 19.<br>Discounted rates available through the BlueCross BlueShield Vision Program |
| | Children's glasses | No charge. Deductible does not apply. | Not covered | |
| | Children's dental check-up | No charge | No charge | Additional services are subject to a separate deductible of $125 per person. $2,000 annual maximum does not apply for individuals under age 19. |

**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<br>• Cosmetic surgery<br>• Infertility treatment | • Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Private-duty nursing<br>• Routine foot care<br>• Weight loss programs (except as required by the ACA) |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Bariatric surgery (preauthorization is required)<br>• Chiropractic care<br>• Dental care (Adult) ($2,000 per person per calendar year) | • Hearing aids (every 5 calendar years up to $1,500) | • Routine eye care (Adult) (up to $300 per calendar year) |

**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 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 1-312-738-2811. 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.

**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 1-312-738-2811.

*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 PPO provider pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$240** |
| **Specialist copayments** | **$40** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $240 |
| Copayments | $40 |
| Coinsurance | $760 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Peg would pay is** | **$1,050** |

## Managing Joe's type 2 Diabetes
(a year of routine PPO provider care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$240** |
| **Specialist copayments** | **$40** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $130 |
| Copayments | $1,260 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | **$1,420** |

## Mia's Simple Fracture
(PPO provider emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$240** |
| **Specialist copayments** | **$40** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $240 |
| Copayments | $160 |
| Coinsurance | $220 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$620** |

**NOTE:** These numbers assume the patient does not participate in the plan's Diabetes Program. If you participate in the plan's Diabetes Program, you may be able to reduce your cost. For more information about the Diabetes Program, please call 1-312-738-2811.
The **plan** would be responsible for the other costs of these EXAMPLE covered services.