




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 <u>deductible</u>?	PPO <u>provider</u> and Non-PPO <u>provider</u> combined: \$240 per person/ \$720 per family.	Generally, you must pay all of the costs from <u>providers</u> 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. PPO <u>provider</u> Prescription Drugs, PPO <u>provider</u> Preventive Care, PPO <u>provider</u> physician, mental health and <u>specialist</u> office visits, Department of Transportation Required Exams and Tests, and vision care from a PPO <u>provider</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you have not 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$125 per person for dental. 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	PPO <u>provider</u> : \$1,000 per person; \$3,000 per family; <u>In-network</u> prescription drugs: \$2,500 per person; \$5,000 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.
What is not included in the <u>out-of-pocket limit</u>?	Non-PPO <u>provider</u> expenses (except for emergency care), <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of PPO <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</u> charge 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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
		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
	<u>Specialist</u> visit	\$40 copay per visit. Deductible does not apply.	35% coinsurance	None
	<u>Preventive care/screening/Immunization</u>	No charge. Deductible does not apply.	Not covered	You may have to pay for services that are not preventive. Ask your <u>provider</u> if the services needed are preventive. Then check with what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	35% coinsurance	Check to see if <u>preauthorization</u> is required or possibly pay a penalty of 50% of eligible charges.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	35% coinsurance	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a penalty of 50% of eligible charges.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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). 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.
	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	No charge for ACA-required generic preventive drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate).
	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	<u>Copays</u> for diabetic drugs and testing supplies are reduced by 50% for those enrolled in the <u>Plan's</u> Diabetes Program.
	<u>Specialty drugs</u>	30% coinsurance or \$0 with enrollment in PrudentRx – limited to a 30-day supply.	Not covered	Effective 1/1/2023 – For <u>specialty drugs</u> , individuals who enroll with PrudentRx will pay \$0 for specialty medications available through the program and covered by the <u>Plan</u> . Visit www.prudentrx.com/prudentrx/ for the PrudentRx Drug List. You may also contact PrudentRx at 1-800-578-4403. As long as you are enrolled with PrudentRx you will pay \$0, otherwise a 30% coinsurance is applicable.

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)	10% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a \$600 penalty.
	Physician/surgeon fees	10% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a \$600 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fees	10% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per office visit; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for other outpatient services.	35% <u>coinsurance</u>	<u>Copay</u> applies only if ComPsych is used.
	Inpatient services	10% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call MAP at 1-866-532-8652. Failure to preauthorize will result in a \$600 penalty. Charges limited to semi-private room rates.

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 are pregnant	Office visits	No charge. <u>Deductible</u> does not apply.	35% <u>coinsurance</u>	Prenatal care (other than ACA-required preventive <u>screenings</u>) is not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Failure to preauthorize stays exceeding 48 hours following a vaginal delivery and 96 hours following a cesarean section will result in a \$600 penalty.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Delivery expenses are not covered for dependent children. Charges limited to semi-private room rates.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	40 visits per calendar year. <u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a penalty of 50% of eligible charges.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a penalty of 50% of eligible charges.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	Coverage limited to speech therapy; <u>plan</u> does not cover <u>habilitation services</u> for physical or occupational therapy.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	90 days per calendar year. <u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a \$600 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. Failure to preauthorize will result in a penalty of 50% of eligible charges.
	<u>Hospice services</u>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Preauthorization</u> is required. Must call Utilization Management at 1-800-441-7705. 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. <u>Deductible</u> does not apply.	Not covered	One exam per calendar year. One pair of frames per calendar year (<u>plan</u> 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.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	Not covered	\$300 annual maximum does not apply to individuals under age 19. Discounted rates available through the BlueCross BlueShield Vision Program
	Children's dental check-up	No charge	No charge	Additional services are subject to a separate <u>deductible</u> 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
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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)
- Chiropractic care
- 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 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 1-312-738-2811. 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

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 1-312-738-2811.

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)

■ <u>The plan's overall deductible</u>	\$240
■ <u>Specialist copayments</u>	\$40
■ <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)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$240
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$760
<i>What isn't covered</i>	
Limits or exclusions	\$20
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)

■ <u>The plan's overall deductible</u>	\$240
■ <u>Specialist copayments</u>	\$40
■ <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)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$1,040
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(PPO provider emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$240
■ <u>Specialist copayments</u>	\$40
■ <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)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$240
<u>Copayments</u>	\$170
<u>Coinsurance</u>	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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.