




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, contact the Fund Office at 1-773-685-0340. 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 1-773-685-0340 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$250/Individual or \$500/family Does not apply to in-network preventive care.	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. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$500 per admission for <u>out-of-network</u> hospitals.	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>?	For Medical <u>network providers</u> : \$2,500 individual / \$5,000 family; For Prescription Drug <u>network providers</u> : \$2,500 individual / \$5,000 family; For <u>out-of-network providers</u> : Not Applicable.	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>?	<u>Premiums</u> , <u>deductibles</u> , <u>balance-billing</u> charges, penalties for failure to pre-certify services and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't 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 <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 plan's <u>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> .
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 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	25% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what you plan will pay for. For <u>out-of-network</u> services, plan pays up to \$1,000 per calendar year.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.magellanrx.com or by contacting Magellan Rx at 1-833-604-0919.	Generic drugs	15% <u>coinsurance</u> , up to \$250 per prescription. (No <u>deductible</u>)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail-order prescription). Certain women's <u>preventive care</u> covered at no cost to the member. For full list of these prescriptions and/or services, please contact Magellan Rx at 1-833-604-0919. <u>Network coinsurance</u> reflects prescriptions filled at Select Osco/CVS retail locations. Other <u>network</u> Magellan Rx pharmacies covered at 25% <u>coinsurance</u> . Mail-Order program covered at 20% <u>coinsurance</u> . No coverage for prescription drugs filled at Walmart or Sam's Club.
	Preferred brand drugs	15% <u>coinsurance</u> , up to \$250 per prescription. (No <u>deductible</u>)	Not Covered	
	Non-preferred brand drugs	15% <u>coinsurance</u> , up to \$250 per prescription. (No <u>deductible</u>)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	100% <u>coinsurance</u> . If <u>coinsurance</u> assistance is unavailable for a drug, its <u>coinsurance</u> defaults to the tiered structure shown above.	Not Covered	Covers up to a 30-day supply. The Fund's contracted Specialty drug case manager will work with drug manufacturers so that the cost to you does not exceed the tiered structure shown above.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <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>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> services. Failure to <u>preauthorize</u> may result in a 15% reduction to benefits.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	For <u>out-of-network</u> facility, \$500 <u>deductible</u> per admission (waived if emergency admission).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> services. Failure to <u>preauthorize</u> may result in a 15% reduction to benefits.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	For <u>out-of-network</u> in-patient facility, \$500 <u>deductible</u> per admission (waived if emergency admission).
If you are pregnant	Office visits	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> services. Failure to <u>preauthorize</u> may result in a 15% reduction to benefits.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <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)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization is required for out-of-network services. Failure to preauthorize may result in a 15% reduction to benefits.
	Rehabilitation services	10% coinsurance	40% coinsurance	
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	
	Durable medical equipment	10% coinsurance	40% coinsurance	
	Hospice services	10% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Coverage limited to one exam per calendar year.
	Children's glasses	No Charge	Provider charge, less up to \$150 per calendar year.	Coverage limited to one pair of glasses or contact lenses per calendar year. Frame or Contact Lens allowance up to \$200 per calendar year with certain network providers.
	Children's dental check-up	No Charge	25% coinsurance	\$2,000 in-network annual maximum. \$500 out-of-network 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.)		
<ul style="list-style-type: none"> Cosmetic Surgery (except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or disease) 	<ul style="list-style-type: none"> Infertility Treatment Long-Term Care Prescription Drugs filled at Walmart or Sam's Club 	<ul style="list-style-type: none"> Routine Foot Care (except in connection with diabetes) Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic Care 	<ul style="list-style-type: none"> Dental Care (Adult) Hearing Aids Non-Emergency care when traveling outside U.S. 	<ul style="list-style-type: none"> Private Duty Nursing Routine Eye Care (Adult)

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: 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: Elite Administration & Insurance Group, Inc. at 1-312-243-1265. You can also contact the Department of Labor, 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 <https://www.healthcare.gov/sbc-glossary/-/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 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 1-773-685-0340.

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$0
■ <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:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,510

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$0
■ <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:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$700
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$970

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$0
■ <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:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$550

Note: These numbers assume the patient participates in the plan's wellness program and receives **Enhanced Benefits**. If you do not participate in the plan's wellness program, the amount patient pays may be higher. For more information about the wellness program, please contact the Fund Office at 1-773-685-0340.