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 deductible?	**$750**/Individual or **$1,500**/family Does not apply to in-network preventive care.	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. Preventive care services 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. $500 per admission for out-of-network hospitals.	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?	For **Medical** network providers: $2,500 individual / $5,000 family; For **Prescription Drug** network providers: $2,500 individual / $5,000 family; For out-of-network providers: Not Applicable.	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, deductibles, balance-billing charges, penalties for failure to pre-certify services and health care this plan doesn't 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. 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
		Network Provider (You will pay the least)	Out-of-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	25% coinsurance	40% coinsurance	None
	Specialist visit	25% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	25% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what you plan will pay for. For out-of-network services, plan pays up to $1,000 per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com or by contacting Magellan Rx at 1-833-604-0919.	Generic drugs	25% coinsurance (No deductible)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail-order prescription). Certain women's preventive care 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. Network coinsurance reflects prescriptions filled at Magellan Rx pharmacies and through Mail-Order program. No coverage for prescription drugs filled at Walmart or Sam's Club.
	Preferred brand drugs	25% coinsurance (No deductible)	Not Covered	
	Non-preferred brand drugs	25% coinsurance (No deductible)	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)	
	Specialty drugs	100% coinsurance. If coinsurance assistance is unavailable for a drug, its coinsurance 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)	25% coinsurance	40% coinsurance	None
	Physician/surgeon fees	25% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	40% coinsurance	
	Urgent care	25% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network services. Failure to preauthorize may result in a 15% reduction to benefits. For out-of-network facility, $500 deductible per admission (waived if emergency admission).
	Physician/surgeon fees	25% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network services. Failure to preauthorize may result in a 15% reduction to benefits. For out-of-network in-patient facility, $500 deductible per admission (waived if emergency admission).
	Inpatient services	25% coinsurance	40% coinsurance	
If you are pregnant	Office visits	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network services. Failure to preauthorize may result in a 15% reduction to benefits. For out-of-network facility, $500 deductible per admission (waived if emergency admission).
	Childbirth/delivery professional services	25% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	40% coinsurance	

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	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network services. Failure to preauthorize may result in a 15% reduction to benefits.
	Rehabilitation services	25% coinsurance	40% coinsurance	
	Habilitation services	25% coinsurance	40% coinsurance	
	Skilled nursing care	25% coinsurance	40% coinsurance	
	Durable medical equipment	25% coinsurance	40% coinsurance	
	Hospice services	25% 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.)

- Cosmetic Surgery (except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or disease)
- Infertility Treatment
- Long-Term Care
- Prescription Drugs filled at Walmart or Sam's Club
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Non-Emergency care when traveling outside U.S.
- 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 Coveragehttps://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 plan's overall deductible	$250
■ Specialist copayment	$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	$250
Copayments	$0
Coinsurance	$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 plan's overall deductible	$250
■ Specialist copayment	$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	$250
Copayments	$0
Coinsurance	$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 plan's overall deductible	$250
■ Specialist copayment	$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	$250
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

Note: These numbers assume the patient does not participate in the plan's wellness program and receives **Non-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.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.