




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? | For <u>network providers</u> : \$1,250 individual/ \$2,500 family For <u>out-of-network providers</u> : \$5,000 individual/ \$10,000 family. Does not apply to <u>in-network</u> 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 deductible? | 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 deductibles for specific services? | No. | 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 out-of-pocket limit for this plan? | For <u>network providers</u> : \$2,500 individual/ \$5,000 family; For <u>out-of-network providers</u> : \$2,500 individual/ \$5,000 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 out-of-pocket limit? | <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 network provider? | 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> . |
|--|-----|--|

 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 | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No charge | 40% <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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <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.primetherapeutics.com or by contacting Prime Therapeutics (Formerly Magellan Rx) at 1-833-604-0919. | Generic drugs | 20% <u>coinsurance</u> | Not Covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs | 20% <u>coinsurance</u> | Not Covered | 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 Prime Therapeutics at 1-833-604-0919. |
| | Non-preferred brand drugs | 20% <u>coinsurance</u> | Not Covered | No coverage for prescription drugs filled at Walmart or Sam's Club. |
| | <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. |

| 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-network air ambulance covered same as in-network. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <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 20% reduction to benefits. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <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 20% reduction to benefits. |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Preauthorization</u> is required for in-patient services. Failure to <u>preauthorize</u> may result in a 20% reduction to benefits. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <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 20% reduction to benefits. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| 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 <u>network providers</u> . |
| | Children's dental check-up | No Charge | 25% <u>coinsurance</u> | \$3,500 <u>in-network</u> annual maximum. \$500 <u>out-of-network</u> 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)
- Long-Term Care
- Prescription Drugs filled at Walmart or Sam's Club
- Routine Foot Care (except in connection with diabetes)

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
- Infertility Treatment
- Non-Emergency care when traveling outside U.S
- Private Duty Nursing
- Routine Eye Care (Adult)
- Weight Loss Programs

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 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 \$1250
- Specialist copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,310 |

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$1250
- Specialist copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,270 |

Mia's Simple Fracture

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

- The plan's overall deductible \$1250
- Specialist copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,650 |

Note: Employee has option to add eligible dependent children on a contributory (self-pay) basis. Spouses excluded from coverage.

