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 is provided separately. This is only a summary of benefits. For more information about your coverage, or to get a copy of the complete terms of coverage, call the Fund Office at 866-732-1919. 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 call 866-732-1919 to request a copy of the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/individual or $1,500/family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 and prescription drug benefits 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 for dental services. $100/individual or $300/family.	You must pay all of the costs for these Non-Preventive 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 in-network providers* $5,000/individual or $10,000/family; for out-of-network providers $10,000/individual or $20,000/family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	The out-of-pocket limit is the most you could pay in a year for covered medical and prescription 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, dental/vision benefits, balance-billing charges (unless balanced-billing is prohibited), 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 800-810-2583 for a list of network providers. **Out-of-Network providers* may be treated as In-Network providers as required by No Surprises Act.*	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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance	40% coinsurance	Telephonic/virtual visits will be paid the same as in-person visits.
	Specialist visit			----------None----------
	Preventive care/screening/ immunization	No charge		You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Some imaging tests require preauthorization.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 866-732-1919	Generic drugs	15% copay with $10 minimum/prescription for retail. $20 copay/ prescription for mail order.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Specialty drugs may be limited to a 30-day supply. Certain prescriptions require prior authorization before being covered by the Plan. The Plan does not cover prescriptions filled at an out-of-network pharmacy.
	Brand drugs	30% copay with $20 minimum/prescription for retail. $60 copay/ prescription for mail.		
	Specialty drugs	30% copay with $20 minimum/prescription for retail. $60 copay/ prescription for mail.		

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% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced or not provided.
	Physician/surgeon fees			Telephonic/virtual visits will be paid the same as in-person visits.
If you need immediate medical attention	Emergency room care	$100 copay/visit + 20% coinsurance	$100 copay/visit + 20% coinsurance unless otherwise required by No Surprises Act	Copay is waived if admitted to hospital from Emergency Room.
	Emergency medical transportation	20% coinsurance	20% coinsurance unless otherwise required by No Surprises Act	
	Urgent care		40% coinsurance unless otherwise required by No Surprises Act	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or not provided.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Preauthorization is required for inpatient services. If you don't get preauthorization, benefits could be reduced or not provided.
	Inpatient services		40% coinsurance unless otherwise required by No Surprises Act	

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 are pregnant	Office visits	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) Preauthorization is required for inpatient services. If you don't get preauthorization, benefits could be reduced or not provided.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	104 visits max per benefit period.
	Rehabilitation services			Physical, Speech and Occupational therapy benefits are limited to 60 visits combined per benefit period. Additional visits may be approved if medically necessary. Preauthorization may be required for some of these services.
	Habilitation services			
	Skilled nursing care			Skilled Nursing Facility is limited to 90 days per benefit period.
	Durable medical equipment			None if medically necessary. Orthotic calendar year maximum - $3,000 Electric/power wheelchair lifetime maximum - $10,000
	Hospice services			None
If your child needs dental or eye care	Routine eye exam	$0 copay	$10 copay and any cost exceeding benefit limit	Coverage limited to one exam per 12 months.
	Glasses	$10 copay and any cost exceeding plan allowance	$10 copay and any cost exceeding benefit limit	Coverage limited to one pair of lenses per 12 months and one pair of frames per 24 months.
	Dental check-up	No charge for preventive care		Preventive dental care limited to 2 cleanings/exams per benefit period. Dental plan benefit is limited to $1,200 per person (age 19 or older) per benefit period.

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 • Bariatric surgery • Cosmetic surgery	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care • Dental care (Adult)	• Hearing aids • 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's 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 866-732-1919.

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 866-732-1919.

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** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
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	$500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
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	$500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **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:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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