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, visit www.iuoe399.org or call 1-312-372-9870. 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 1-312-372-9870 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** per individual or **$1,200** per family.	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You will have to meet the deductible before the plan pays for any services.
What is the out-of-pocket limit for this plan?	**$5,000** in-network services only	The out-of-pocket limit is the most you could pay in a year for covered services. Each member must meet the out-of-pocket limit individually.
What is not included in the out-of-pocket limit?	Out-of-network coinsurance, Prescription drugs, premiums, balance-billing charges, 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

 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	10% coinsurance	30% coinsurance	None.
	Specialist visit	10% coinsurance	30% coinsurance	Coverage is limited to $1,000 per year for chiropractic.
	Preventive care/screening/ immunization	10% coinsurance	Not covered except as described (30% coinsurance for covered services).	Well-child visits and immunizations through age 18, annual adult physicals, adult immunizations recommended by the Center for Disease Control, adult diagnostic services recommended by the U.S. Preventive Services Task Force, and the facility fee for colonoscopy screenings are covered when provided by a network provider. Mammograms for women over age 40, gynecological exams and tests, and PSA testing over age 45, and screening colonoscopies over age 45 are covered when provided by either a network provider or out-of-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization is required covered genetic testing. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com	Generic drugs	30% coinsurance, the deductible does not apply	Not covered	Covers up to a 30-day supply for retail or up to 90-day supply for mail-order. No coverage for prescriptions filled at Sam's Club or Walmart. Coinsurance does not apply to the out-of-pocket limit.
	Brand drugs	40% coinsurance for retail, 30% coinsurance for mail-order, the deductible does not apply	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered.	Preauthorization is required. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copayment	30% coinsurance after $100 copayment	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	None.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None.

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	30% coinsurance	Preauthorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization is required. No coverage for developmental therapy.
	Habilitation services	Not covered.	Not covered.	None.
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$10 copayment	Amount in excess of $150 for exam, lenses, and frames combined.	Benefit limited to once per calendar year. Charges for services provided by Wal-Mart or Sam's Club are not covered.
	Children's glasses	$20 copayment for single & lined multi-focal lenses; amount in excess of $200 for frames		
	Children's dental check-up	0% coinsurance	50% coinsurance	None.

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
- Developmental therapy
- Habilitative services
- Infertility treatment
- Long-term care
- Out-of-network surgical centers
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture up to $1,000 per year
- Bariatric surgery subject to specific criteria
- Chiropractic care up to $1,000 per year
- Dental care (adult)
- Foot Orthotics once every three years
- Genetic testing services up to $2,500 per person per calendar year and $10,000 lifetime maximum
- Hearing aids up to $2,000 per ear every three years
- Non-emergency care when traveling outside the U.S., but only for persons who are absent from the U.S. for fewer than 60 days
- Nutritional counseling sessions up to two times per person (only for newly diagnosed diabetics and those with a mental health disorder)
- Private duty nursing when determined by the review organization to be medically necessary and appropriate
- Routine eye care (adult)
- Routine foot care, meaning medical care for diseases such as diabetes, and medical conditions of the foot

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 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: 1-312-372-9870.

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 1-312-372-9870.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-312-372-9870.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-312-372-9870.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-312-372-9870.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.iuoe399.org or call 1-312-372-9870.]

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	$300
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$300
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,600**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$300
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$300
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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