




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](http://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](http://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 <a href="#">deductible</a> ?	\$300 per individual or \$1,200 per family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000 per individual for in-network services only.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. Each member must meet the <a href="#">out-of-pocket-limit</a> individually.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Out-of-network <a href="#">coinsurance</a> , prescription drugs, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage is limited to \$1,000 per year for chiropractic.
	<a href="#">Preventive care/screening/immunization</a>	10% <a href="#">coinsurance</a>	Not covered except as described (30% <a href="#">coinsurance</a> 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 <a href="#">network provider</a> .  Mammograms for women over age 40, gynecological exams and tests, PSA testing over age 45, and screening colonoscopies over age 45 are covered when provided by either a <a href="#">network provider</a> or <a href="#">out-of-network provider</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required covered for genetic testing.  Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Caremark.com">www.Caremark.com</a>	Generic drugs	30% <a href="#">coinsurance</a> , the <a href="#">deductible</a> does not apply	Not covered	Covers up to a 30-day supply for retail or up to 90-day supply for mail-order.
	Brand drugs	40% <a href="#">coinsurance</a> for retail, 30% <a href="#">coinsurance</a> for mail-order, the <a href="#">deductible</a> does not apply	Not covered	No coverage for <a href="#">prescriptions</a> filled at Sam's Club or Walmart.  Coinsurance does not apply to the <a href="#">out-of-pocket limit</a> .

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% <a href="#">coinsurance</a>	Not covered.	<a href="#">Preauthorization</a> is required.  Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after \$100 <a href="#">copayment</a>	30% <a href="#">coinsurance</a> after \$100 <a href="#">copayment</a>	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.  Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.  Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <a href="#">network</a> rate for certain charges from <a href="#">out-of-network providers</a> when received at a <a href="#">network</a> facility or during an emergency medical condition. For more information, contact the Benefit Office.

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

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	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Habilitation services</a>	Not covered.	Not covered.	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copayment</a>	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 <a href="#">copayment</a> for single & lined multi-focal lenses; amount in excess of \$200 for frames		
	Children's dental check-up	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
• Cosmetic surgery	• Infertility treatment	• Habilitation services (except ABA therapy for autism)
• Long-term care	• <a href="#">Out-of-network</a> surgical centers	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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) up to \$3,500 per year	• 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
• 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, plus orthotics once every three years

**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](http://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](http://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, kwijigo holne' 1-312-372-9870.]

*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](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$1,600</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,500</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>