




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 individual / \$1,200 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
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 in-network only	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Prescription drug coinsurance, <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</a> office 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).	Covered when in-network (only): <ul style="list-style-type: none"> <li>• Well-child visits and immunizations through age 18</li> <li>• Annual adult physicals</li> <li>• Adult immunizations recommended by the Center for Disease Control</li> <li>• Adult diagnostic services recommended by the U.S. Preventive Services Task Force</li> <li>• Facility fee for screening colonoscopy</li> </ul> Covered in- or out-of-network: <ul style="list-style-type: none"> <li>• Mammograms over age 40, gynecological exams/tests, and PSA test over age 45</li> <li>• Screening colonoscopies over age 50</li> </ul>
<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>	No coverage for genetic testing.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
<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>	100%	No coverage for prescriptions filled at Sam's Club or WalMart.
	Brand drugs	40% <a href="#">coinsurance</a> (retail), 30% (mail-order)	100%	Covers up to a 30-day supply (retail prescription); up to 90 day supply (mail-order). Coinsurance does not apply to the out-of-pocket limit.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not covered.	Pre-certification is required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.

[\* 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 need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after \$100 co-pay	30% <a href="#">coinsurance</a> after \$100 co-pay	None.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-certification is required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-certification is required.
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>	Pre-certification is required.
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>	Pre-certification is required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-certification is required. No coverage for developmental therapy.
	<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>	Pre-certification is required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-certification is required.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Pre-certification 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 & 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 \$130 for frames		
	Children's dental check-up	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.

[\* 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.]

## 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> .)		
• Acupuncture	• Cosmetic surgery	• Developmental therapy
• Genetic testing	• Habilitative services	• Hearing aids
• 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 <a href="#">plan</a> document.)		
• Bariatric surgery subject to specific criteria	• Chiropractic care up to \$1,000 per year	• Dental care (adult)
• Routine foot care, meaning medical care for diseases such as diabetes, and medical conditions of the foot	• Private duty nursing when determined by the review organization to be medically necessary and appropriate	• 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](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.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$1,170
<i>What isn't covered</i>	
Limits or exclusions*	\$720
<b>The total Peg would pay is</b>	<b>\$2,190</b>

\* Genetic tests and OTC vitamins excluded.

**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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$2,260
<i>What isn't covered</i>	
Limits or exclusions**	\$20
<b>The total Joe would pay is</b>	<b>\$2,580</b>

\*\* OTC products excluded.

**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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$560</b>

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