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.csjbunion.org/healthandwelfare or call 1-312-738-0822. 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.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For **in-network providers** and **out-of-area providers: $700** per person/**$2,100** per family/calendar year; for **out-of-network providers:** Not applicable.	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, in-network **preventive care** is 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For **in-network providers** and **out-of-area providers: $3,500** per person/**$10,500** per family/calendar year; For **out-of-network providers:** Not applicable. Prescription Drugs**: $3,850** per person/**$4,200** per family / calendar year.	The **out-of-pocket limit** is the most you could pay in a year for covered 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?	Penalties for failure to obtain pre-authorization, premiums, balance-billed 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. For a list of **preferred providers**, see www.bcbsil.com or call 1-888-810-BLUE.	This **plan** uses a **provider network** and does not cover **out-of-network providers, except** Emergency Room treatment. You will pay less if you use a **provider** in the **plan's network**. You 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**.

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		
		In- Network and Out-of-Area Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 **copayment** /office visit	Not Covered	----------none----------
	Specialist visit	$50 **copayment** /office visit	Not Covered	Chiropractic services limited to $500 per year.
	Preventive care/screening/ immunization	No Charge (**deductible** does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of covered **preventive services** at www.healthcare.gov/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	Not Covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		
		In- Network and Out-of-Area Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxsolutions.com	Generic Drugs	Retail and Mail order: 10% **coinsurance**, with a $200 maximum per prescription		**$3,850** per person/**$4,200** per family in-network **out-of-pocket limit** per calendar year. Maintenance drugs must be filled through the OptumRx Mail Service Pharmacy, which covers up to a 90-day supply.
	Brand Drugs	Retail and Mail order: 35% **coinsurance**, with a $200 maximum per prescription		
	Brand Drugs when Generic is Available	Retail and Mail order: 35% **coinsurance** plus 100% of the difference in cost of the generic and brand name medication, with a $200 maximum per prescription		
	Specialty Drugs	20% **coinsurance**, with a $250 maximum per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	Not Covered	Certain types of surgeries must be performed on an Outpatient basis. Pre-certification required; otherwise, you must pay $500, which does not count toward your deductible or **out-of-pocket limit**.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$200 **copayment**/emergency room visit	Not Covered	Copayment waived if admitted to Hospital within 48 hours of treatment. Certification required within 24 hours of admission; otherwise, you must pay $500, which does not count toward your deductible or **out-of-pocket limit**.
	Emergency medical transportation	20% **coinsurance**	Not Covered	Coverage limited to first trip to and/or from Hospital for any one sickness or for all injuries resulting from any one accident.
	Urgent care	$25 **copayment**	Not Covered	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		
		In- Network and Out-of-Area Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your deductible or **out-of-pocket limit**.
	Physician/surgeon fees	20% **coinsurance**		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% **coinsurance**	Not Covered	Pre-certification required for inpatient and outpatient services; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**. Pre-certification requirement does not apply to office visits.
	Inpatient services			
If you are pregnant	Office visits	20% **coinsurance**	Not Covered	**Cost sharing** does not apply for **preventive services**. Preventive care services are covered at no cost.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your deductible or **out-of-pocket limit**. Limited to 60 visits per calendar year. If not arranged through Case Management Service, you must pay 30% **coinsurance** and are limited to 40 visits per calendar year.
	Rehabilitation services	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**.
	Habilitation services	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**.

Common Medical Event	Services You May Need	What You Will Pay		
		In- Network and Out-of-Area Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
				Chiropractic services limited to $500 per year.
	Skilled nursing care	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**. Limited to 150 confinement days per calendar year. If not arranged through Case Management Services, you must pay 30% **coinsurance** and are limited to 120 confinement days per calendar year.
	Durable medical equipment	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**.
	Hospice services	20% **coinsurance**	Not Covered	Pre-certification required; otherwise, you must pay $500, which does not count toward your **deductible** or **out-of-pocket limit**. If not arranged through Case Management Services, you must pay 30% **coinsurance**.
If your child needs dental or eye care	Children's eye exam	Not Covered		Vision screening for children is covered as preventive service with no charge.
	Children's glasses			
	Children's dental check-up			

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
- Cosmetic surgery (unless performed to correct congenital defect, defects incurred through traumatic injury, or malfunctioning organs)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-Emergency care when traveling outside the United States
- Private duty nursing
- Routine eye care (Adult) and

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

- Bariatric surgery
- TMJ Disorder ($2,000 lifetime maximum)
- Infertility treatment ($5,000 lifetime maximum)
- Chiropractic care ($500 calendar year maximum)

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 the Plan at 1-312-738-0822. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Illinois Department of Insurance at 1-877-527-9431 or http://insurance.illinois.gov/.

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.

For more information about limitations and exceptions, see the plan document at www.csjbunion.org or call 1-312-738-0822.

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:

Para obtener asistencia en Español, llame al 1-312-738-0822.

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	$700
Specialist copayment	$50
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$50
Coinsurance	$2,500
What isn't covered	
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	$700
Specialist copayment	$50
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$300
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,760

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

The plan's overall deductible	$700
Specialist copayment	$50
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$150
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,180

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