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.ibew701fbo.com or call 1-630-393-1701 #3. 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 1-630-393-1701 #3 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** per individual or **$800** 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, in-network office visits, imaging services provided by Absolution Solutions and generic prescription drugs 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. **$200** for emergency room and **$100** for utilization review non-compliance. There are no other specific deductibles.	You must pay all of the costs for these 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?	**$2,500** per individual or **$5,000** per family for network providers; **$5,000** per individual or **$10,000** per family for out-of-network providers.	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?	Premiums, balance-billing charges, failure to obtain preauthorization, 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.

⚠ 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	$25 copayment	30% coinsurance	None.
	Specialist visit	$25 copayment	30% coinsurance	Chiropractor visits are subject to 10% coinsurance for network providers, 30% for out-of-network providers, and are limited to a $1,000 maximum annually.
	Preventive care/screening/ immunization	No charge.	30% coinsurance	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)	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.
	Imaging (CT/PET scans, MRIs)	No charge in Absolute Solutions network, 30% coinsurance in BCBSIL network	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	$5 copayment retail, $15 copayment 90-day retail, $10 copayment mail-order	Amount in excess of SavRx negotiated price plus your copayment. Submit claims to SavRx.	30-day retail fills are mandatory for first two fills of a long-term/ maintenance drug. Mail-order or 90-day retail is mandatory for the fourth and all subsequent fills. Mandatory generic, step therapy, specialty drug, and prior authorization programs in effect. 90-day retail option is only available through Walgreens. Wal-Mart and Sam's Club are not in your network. Gene therapy is excluded. Home infusion therapies are available at $0. If the same therapies are performed away from the home, regular coinsurance applies. Preauthorization is required.
	Preferred brand drugs	20% coinsurance with a $20 min/$30 max retail, $55 copayment 90-day retail, $40 copayment mail-order		
	Non-preferred brand drugs	20% coinsurance with a $25 min/$45 max retail, $85 copayment 90-day retail, $55 copayment mail-order		

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.	Additional $100 deductible applies if preauthorization is not obtained. 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 immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	$200 deductible applies unless admitted or if the visit is for a true emergency. 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	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.
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Additional $100 deductible applies if preauthorization is not obtained. 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	

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 mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	$25 copayment applies to network provider office visits for counseling or medication management; the Plan pays 100% of balance.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for inpatient and residential stays. Partial inpatient and intensive outpatient treatment requires preauthorization after twelve visits. Facility must be in IL, state of residence, or state where enrolled as a full-time college student unless exception granted. Additional $100 deductible applies if preauthorization is not obtained. Up to a maximum of 45 days for all related confinements.
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	Preauthorization is required for confinements in excess of 48 hours (96 hours for C-section). Additional $100 deductible applies if preauthorization is not obtained.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical/occupational therapy requires preauthorization after twelve visits per disability.
	Habilitation services	10% coinsurance	30% coinsurance	Speech therapy is covered for autism; congenital neurological, or anatomical disorder; hearing deficit caused by an illness; and dysphagia. Limited to 40 visits per year for children up to age twelve. All other habilitative services are excluded.
	Skilled nursing care	10% coinsurance	30% coinsurance	Room & board is limited to 50% of the semi-private room rate at the discharging hospital. Facility must be in IL, state of residence, or state where enrolled as a full-time college student unless exception granted. Additional $100 deductible applies if preauthorization is not obtained. Up to a maximum of 45 days for all related confinements.

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)	
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is recommended.
	Hospice services	10% coinsurance	30% coinsurance	Coverage is limited to 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge.	Amount over $50	Exams are allowed every year.
	Children's glasses	No charge for lenses, amount over $50 for frames (contracted cost)	Amount over $125 for frames and over $65 for lenses	Payable on single vision plastic lenses. Frames are allowable every two years. Lenses are allowable every year.
	Children's dental check-up	No charge.	No charge.	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.)		
• Acupuncture	• Cosmetic surgery	• Habilitation services unless a specific exception is listed above
• Long-term care	• Private-duty nursing	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery if pre-certified, subject to coverage criteria; one per lifetime; not covered for children	• Chiropractic care up to $1,000 per year	• Dental care (Adult) up to a maximum of $3,000 per year per person
• Foot orthotics up to a maximum of two pairs every three years	• Hearing aids up to $1,500 every three years and hearing exams up to $75 every two calendar years	• Infertility treatment up to $10,000 per lifetime per person
• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)	• Weight loss programs if physician-supervised, up to $1,000 per lifetime (participant and spouse only)
• Refractive surgery (i.e., Lasik) up to $750 per eye per lifetime	• Treatment and/or replacement of congenitally missing teeth up to $5,000 per lifetime	

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: 1-630-393-1701 #3.

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 1-630-393-1701 #3.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-630-393-1701 #3.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-630-393-1701 #3.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-630-393-1701 #3.]

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

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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	$400
Specialist *[cost sharing]*	$25
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	$400
Copayments	$10
Coinsurance	$1,220
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,690**

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

The plan's overall deductible	$400
Specialist *[cost sharing]*	$25
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	$400
Copayments	$360
Coinsurance	$460
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,240**

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

The plan's overall deductible	$400
Specialist *[cost sharing]*	$25
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	$400
Copayments	$80
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

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