




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](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-630-393-1701 #3 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$800</b> per individual or <b>\$1,600</b> per 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. 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 <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , <a href="#">in-network</a> office visits, imaging services provided by Absolution Solutions, and generic <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. <b>\$200</b> for emergency room and <b>\$100</b> for utilization review non-compliance. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$4,000</b> per individual or <b>\$8,000</b> per family for <a href="#">network providers</a> ; <b>\$8,000</b> per individual or <b>\$16,000</b> per family for <a href="#">out-of-network providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, failure to obtain <a href="#">preauthorization</a> , 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	Chiropractor visits are subject to 30% <a href="#">coinsurance</a> for <a href="#">network providers</a> , 50% for <a href="#">out-of-network providers</a> , and are limited to a \$1,000 maximum annually.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <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.
	Imaging (CT/PET scans, MRIs)	No charge in Absolute Solutions network, 30% <a href="#">coinsurance in BCBSIL network</a>	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.savrx.com">www.savrx.com</a> .	Generic drugs	\$5 <a href="#">copayment</a> retail, \$15 <a href="#">copayment</a> 90-day retail, \$10 <a href="#">copayment</a> mail	Amount in excess of SavRx negotiated price plus your <a href="#">copayment</a> . 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.
	Preferred brand drugs	20% <a href="#">coinsurance</a> with a \$20 min/\$30 max retail, \$55 <a href="#">copayment</a> 90-day retail, \$40 <a href="#">copayment</a> mail-order		
	Non-preferred brand drugs	20% <a href="#">coinsurance</a> with a \$25 min/\$45 max retail, \$85 <a href="#">copayment</a> 90-day retail, \$55 <a href="#">copayment</a> mail-order		
				Home infusion therapies are available at \$0. If the same therapies are performed away from the home, regular <a href="#">coinsurance</a> applies. <a href="#">Preauthorization</a> is required.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ibew701fbo.com](http://www.ibew701fbo.com) or call 1-630-393-1701 #3.]

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)	30% <a href="#">coinsurance</a>	Not covered.	Additional \$100 <a href="#">deductible</a> applies if <a href="#">preauthorization</a> is not obtained. 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	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$200 <a href="#">deductible</a> 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 <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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	50% <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 have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Additional \$100 <a href="#">deductible</a> applies if <a href="#">preauthorization</a> is not obtained. 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	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$25 <a href="#">copayment</a> applies to <a href="#">network provider</a> office visits for counseling or medication management; the Plan pays 100% of balance.
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient and residential stays. Partial inpatient and intensive outpatient treatment requires <a href="#">preauthorization</a> 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 <a href="#">deductible</a> applies if <a href="#">preauthorization</a> is not obtained. Up to a maximum of 45 days for all related confinements.
<b>If you are pregnant</b>	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for confinements in excess of 48 hours (96 hours for C-section). Additional \$100 <a href="#">deductible</a> applies if <a href="#">preauthorization</a> is not obtained.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 100 visits per year.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Physical/occupational therapy requires <a href="#">preauthorization</a> after twelve visits per disability.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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 <a href="#">deductible</a> applies if <a href="#">preauthorization</a> is not obtained. Up to a maximum of 45 days for all related confinements.

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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)	
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 180 days per lifetime.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• 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 <a href="#">plan</a> 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)
• Treatment and/or replacement of congenitally missing teeth up to \$5,000 per lifetime	• Refractive surgery (i.e., Lasik) up to \$750 per eye 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](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

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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, kwijigo 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](#) \$800
- [Specialist \[cost sharing\]](#) \$25
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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>	\$800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$800
- [Specialist \[cost sharing\]](#) \$25
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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>	\$800
<a href="#">Copayments</a>	\$320
<a href="#">Coinsurance</a>	\$770
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,910</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$800
- [Specialist \[cost sharing\]](#) \$25
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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>	\$800
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,320</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.