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, call 1-708-449-7373. 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.http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.com or call 1-708-449-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** individual **$750** family (maximum of 3 individual deductibles per family per calendar year)	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over each January 1. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	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. **$25** for prescription drugs per person. 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?	**$1,250** per individual for PPO medical.	The out-of-pocket limit is the most you could pay during the coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billing, health care services this plan does not cover, deductibles, covered services at non-PPO hospitals and ambulatory surgical facilities or by non-PPO physicians, and copayments for failure to obtain preauthorization for certain services.	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 participating providers, visit www.bcbsil.com or call 1-800-810-BLUE (2583) or call the Fund Office at 1-708-449-7373.	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	15% coinsurance	30% coinsurance	None.
	Specialist visit	15% coinsurance	30% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
	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)	20% coinsurance (in facility) 15% coinsurance (in physician's office)	30% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
	Imaging (CT/PET scans, MRIs)	20% coinsurance (in facility) 15% coinsurance (in physician's office)	30% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: 10% coinsurance, $5 minimum Mail: 10% coinsurance, $10 minimum	10% coinsurance	Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Preferred brand drugs	Retail: 20% coinsurance, $15 if no generic available Mail: 20% coinsurance, $30 minimum if no generic available	20% coinsurance	If generic is available, 30% coinsurance applies instead and minimums and maximums as noted. Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Non-preferred brand drugs	Retail: 30% coinsurance, $25 minimum, $50 maximum	30% coinsurance	If generic is available, 30% coinsurance applies instead and minimums and maximums as noted.

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)	
		Mail: 30% coinsurance, $50 minimum, $100 maximum		Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
If you need immediate medical attention	Emergency room care	20% coinsurance (facility) 15% coinsurance (physician)	20% coinsurance (30% if non-emergency)	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance (facility) 15% coinsurance (physician)	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Private room covered only if semi-private not available.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance (facility) 15% coinsurance (physician)	30% coinsurance	None.
	Inpatient services	20% coinsurance (facility) 15% coinsurance (physician)	30% coinsurance	None.
If you are pregnant	Office visits	15% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have	Home health care	15% coinsurance	20% coinsurance	None.
	Rehabilitation services	20% coinsurance (facility) 15% coinsurance (physician)	30% coinsurance	Rehabilitative speech therapy to restore normal speech only if lost due to stroke or

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)	
other special health needs				injury. For functional purposes not covered. Coinsurance does not apply to services under Hospice Care Program (covered 100%).
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance (facility) 15% coinsurance (physician)	Not covered	Pre-certification of PPO in-network status required. Coinsurance does not apply to services under Hospice Care Program (covered 100%).
	Durable medical equipment	20% coinsurance	20% coinsurance	Coinsurance does not apply to services under Hospice Care Program (covered 100%).
	Hospice services	No cost.	No cost.	No deductible or coinsurance applies. 16-day limit for inpatient and 80-day limit for outpatient.
If your child needs dental or eye care	Children's eye exam	No cost.	No charge up to $50	Not subject to deductible.
	Children's glasses	No charge up to $425 during consecutive two-year period; 20% off balance over $425	No charge up to $250	Not subject to deductible.
	Children's dental check-up	Not covered.	Not covered.	Not covered.

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.)

- Cosmetic Surgery
- Dental care (Adult)
- Gene Therapy Treatments and Gene Therapy Prescription Drugs
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (unless medically necessary)
- Routine foot care
- Speech therapy (for functional purposes, including, but not limited to: stuttering, stammering, and conditions of psychoneurotic origin, or for developmental speech delays)
- Weight loss programs (except as required under preventive services mandate)

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

- Acupuncture
- Bariatric Surgery (subject to certain conditions)
- Hearing Aids (up to $1,250 per device)
- Routine eye care (Adult)

[* For more information about limitations and exceptions, see the plan or policy document at www.sm73funds.org]

• Chiropractic care (up to 20 visits per calendar year)	• Infertility Treatment (50% coinsurance up to $20,000 per couple per lifetime for treatments of infertility)

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: the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 Fund Office at 1-708-449-7373. Additionally, assistance may be provided by your local EBSA office by calling 1-866-444-3272.

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 1-708-449-2122.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.sm73funds.org]

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 in-network coverage.**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist coinsurance	**15%**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**15%**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$275
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,195**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**15%**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$275
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$775**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office at 1-708-449-7373.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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