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: **$1,000** per person/ **$3,000** 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 and wellness benefits 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 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. | 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-billing 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 (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 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 /office visit | Not Covered | ----------None---------- |
| | Specialist visit | $50 copayment /office visit | Not Covered | Chiropractic services subject to 20% coinsurance and 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---------- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.rxsolutions.com | | **Retail (30-day supply) or Mail (90-day supply)** | | $5,950 per person/$8,400 per family in-network out-of-pocket limit per calendar year.<br><br>Maintenance drugs must be filled through the OptumRx Mail Service Pharmacy, which covers up to a 90-day supply. |
| | Generic drugs | 10% coinsurance, with a $200 maximum per prescription | Not Covered | |
| | Brand drugs | 35% coinsurance, with a $200 maximum per prescription | Not Covered | |
| | Brand drugs when Generic is available | 35% coinsurance, with a $200 maximum per prescription, plus 100% of the difference in cost of the generic and brand name medication | Not Covered | |
| | Specialty drugs | 20% coinsurance, with a $250 maximum per | Not Covered | |

| 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) | |
| | | prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | | Certain types of surgeries must be performed on an outpatient basis. Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit. |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance after $400 copayment per emergency room visit | | Copayment waived if admitted to Hospital within 48 hours of treatment. |
| | Emergency medical transportation | 20% coinsurance | Not Covered except air ambulances covered at 20% coinsurance | 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---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit. |
| | Physician/surgeon fees | | | |
| **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 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 if arranged through Case Management Services | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit.<br><br>Limited to 60 visits per calendar year. If not arranged through Case Management Service, you must pay 30% coinsurance and are limited to 40 |

| 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) | |
| | | | | visits per calendar year. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, 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 a $500 penalty, which does not count toward your deductible or out-of-pocket limit. |
| | Skilled nursing care | 20% coinsurance if arranged through Case Management Services | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit.<br><br>If not arranged through Case Management Services, you must pay 30% coinsurance. |
| | Durable medical equipment | 20% coinsurance | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit. |
| | Hospice services | 20% coinsurance if arranged through Case Management Services | Not Covered | Pre-certification required; otherwise, you must pay a $500 penalty, which does not count toward your deductible or out-of-pocket limit.<br><br>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)

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

- Bariatric surgery
- Chiropractic care ($500 calendar year maximum)
- Infertility treatment ($5,000 lifetime maximum; Employee and eligible Spouse only)
- Routine foot care
- Weight loss program (if 100% over medically desired weight; threat to life; and medical history of unsuccessful attempt to lose weight by other methods)

**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 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.**
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 1-312-738-8022.

*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 | $1,000 |
| 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** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $0 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,360** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| 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** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $300 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,320** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| 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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $600 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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