



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.csibunion.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 <u>in-network providers</u> and <u>out-of-area providers</u> : \$700 per person/ \$2,100 per family per calendar year; for <u>out-of-network providers</u> : Not applicable.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, <u>in-network preventive care</u> and wellness benefits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>in-network providers</u> and <u>out-of-area providers</u> : \$3,500 per person/ \$10,500 per family per calendar year; for <u>out-of-network providers</u> : Not applicable.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>preferred providers</u> , see www.bcbsil.com or call 1-888-810-BLUE (2583) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copayment</u> /office visit	Not Covered	-----None-----
	<u>Specialist</u> visit	\$50 <u>copayment</u> /office visit	Not Covered	Chiropractic services subject to <u>20% coinsurance</u> and limited to \$500 per year.
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge (<u>Deductible</u> 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 <u>plan</u> will pay for. See a list of covered <u>preventive</u> services at: www.healthcare.gov/coverage/preventive-care-benefits/ .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	-----None-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Retail (30-day supply) or Mail (90-day supply)			
	Generic drugs	10% <u>coinsurance</u> , with a \$200 maximum per prescription	Not Covered	\$7,100 per person/ \$10,700 per family <u>in-network out-of-pocket limit</u> per calendar year.
	Brand drugs	35% <u>coinsurance</u> , with a \$200 maximum per prescription	Not Covered	
	Brand drugs when Generic is available	35% <u>coinsurance</u> , with a \$200 maximum per prescription, plus 100% of the difference in cost of the generic and brand name medication	Not Covered	You can receive up to a 90-day supply of maintenance drugs through Express Scripts Home Delivery Pharmacy or at an eligible in-network retail pharmacy. To find participating pharmacies, log in at www.express-scripts.com .
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , with a \$250 maximum per prescription	Not Covered	

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

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 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 \$200 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)			
	Physician/surgeon fees	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services			
	Inpatient services	20% coinsurance	Not Covered	Pre-certification required for inpatient and outpatient services; otherwise, you must pay a \$500 penalty, which does not count toward your deductible or out-of-pocket limit. Pre-certification requirement does not apply to office visits.
If you are pregnant	Office visits			
	Childbirth/delivery professional services	20% coinsurance	Not Covered	Cost-sharing does not apply for preventive services. Preventive services are covered at no cost.
	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. Limited to 60 visits per calendar year. If not arranged through Case Management Services, 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 a \$500 penalty, which does not count toward your deductible or out-of-pocket limit.

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

	Habituation services	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your deductible or <u>out-of-pocket limit</u> .
	Skilled nursing care	20% <u>coinsurance</u> 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 <u>out-of-pocket limit</u> . If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
	Durable medical equipment	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your deductible or <u>out-of-pocket limit</u> .
	Hospice services	20% <u>coinsurance</u> 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 <u>out-of-pocket limit</u> . If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam	Not Covered		Vision screening for children is covered as a <u>preventive service</u> 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 medical lifetime maximum; \$5,000 prescription 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 Fund 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 www.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 1-312-738-0822.
Pennsylvania Dutch (Deutsch): Fer Hilf grieve in Deutsch, ruf 1-312-738-0822 uff.

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	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$700
Copayments	\$0
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,160

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	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$700
Copayments	\$300
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$700
Copayments	\$400
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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