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 (708) 597-1832. 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 https://www.healthcare.gov/sbc-glossary/ or call (708) 597-1832 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $500/individual or $1,500/family Out-of-Network: $660/individual or $1,980/family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 In-Network Prescriptions 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 in-network 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. Dental Benefit – $75/individual or $225/family. Ortho and periodontal - $75/individual or $225/family. 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?	Medical In-Network*: $3,000/individual or $9,000/family Medical Out-of-Network: $5,760/individual Prescription In-Network: $3,850/ individual or $4,700/family **Certain medical out-of-network claims are treated as medical in-network claims as required by No Surprises Act.*	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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes.* See www.bcbsil.com or call (800) 571-1043 for a list of network providers. You can also call the Fund Office at (708) 597-1832. **Out-of-network providers* may be treated as *network providers* as required by No Surprises Act.*	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
		In-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	40% coinsurance	MDLIVE Telemedicine - no copayment, deductible or coinsurance. MDLIVE Telemedicine is an In-Network benefit only – no coverage for a telemedicine program other than MDLIVE. Virtual visits provided by a physician's office in lieu of face to face will be covered under standard rates, including the deductible and applicable coinsurance.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No charge	40% coinsurance	In-Network providers not subject to the deductible. 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. For specific benefits and limitations, see Plan at Section 12.06*.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	No deductible, copayment or coinsurance on tests provided by Absolute Solutions Network or on COVID-19 testing at any provider (in-network or out-of-network). See the Plan at Section 5.28*.

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)			No deductible or coinsurance on tests provided by Absolute Solutions Network. See the Plan at Section 5.28*.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxor.com **For Medicare:** (708) 223-2239 **For Non-Medicare:** (806) 316-8482 **For Paydhealth:** (877) 869-7772	Generic drugs	Retail – $8/prescription Mail Order – $11/prescription	Retail - 40% of actual charge after the Major Medical deductible and the applicable In-Network copayment. Mail Order – Not Covered	No deductible on In-Network Prescription Benefits. Present Prescription Drug Card at time of retail purchase. If card is not presented, it will be treated as an out-of-network purchase and you may submit receipt for reimbursement. Retail is up to 90-day supply. Specialty is up to 30-day supply. Mail Order is up to 90-day supply. If generic equivalent is available; you will be required to pay the applicable copayment plus the price difference between the generic drug and the formulary brand name drug, unless the brand name is Medically Necessary as determined by your Physician and the PBM. Certain prescriptions may be subject to prior authorization, step therapy, and/or quantity limit clinical rules. Certain brand or specialty drugs may only be available through Paydhealth. Please contact the Fund Office at (708) 597-1832 with questions. See the Plan at Section 7.04 for Prescription Exclusions*.
	Preferred brand drugs	Retail – $30/prescription Mail Order – $50/prescription		
	Non-preferred brand drugs	Retail – $50/prescription Mail Order – $90/prescription		
	Specialty drugs	Retail - 20% up to $100 max Mail Order – 20% up to $100 max	Retail - 40% of actual charge after the Major Medical deductible and the applicable In-Network copayment. Mail Order – Not Covered	

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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)	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	$200 copayment per person per visit unless moderate to severe conditions as reported by the ER or inpatient admission.
	Emergency medical transportation			----------none----------
	Urgent care			MDLIVE Telemedicine - no copayment, deductible or coinsurance. MDLIVE Telemedicine is an In-Network benefit only – no coverage for a telemedicine program other than MDLIVE. Virtual visits provided by a physician's office in lieu of face to face will be covered under standard rates, including the deductible and applicable coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Limited to semi-private room rate.
	Physician/surgeon fees			----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Consider MAP program for assistance first. Virtual visits provided by a physician's office in lieu of face to face will be covered under standard rates, including the deductible and applicable coinsurance.
	Inpatient services			----------none----------

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Pregnancy of a dependent child not covered except under very limited circumstances. Cost-sharing does not apply to preventive services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child not covered except under very limited circumstances.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Treatment must be within 90 days following a Hospital stay or Convalescent Facility stay of at least five days.
	Rehabilitation services			Limited to 20 visits per illness before review required for Medically Necessity. Physical Therapy received through ATI Physical Therapy's ATI PT First program is covered at 100% with no copayment, deductible or coinsurance.
	Habilitation services	15% coinsurance	40% coinsurance	Limited to certain illness and conditions. Refer to Plan at Sections 5.19, 5.23 and 5.26*. Physical Therapy received through ATI Physical Therapy's ATI First program is covered at 100% with no copayment, deductible or coinsurance.
	Skilled nursing care			Limited to lesser of semi-private room rate or 50% of prior hospital semi-private room rate.
	Durable medical equipment			It is recommended to contact the Fund Office at (708) 597-1832 prior to purchase.
	Hospice services			----------none----------

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursement up to $35	Exam limited to once each calendar year. Out-of-Network charges are reimbursed after claim form submitted.
	Children's glasses	Frames: No charge up to $300 Lenses: No charge	Frames: Reimbursement up to $75 Lenses: Reimbursement up to: Single – $25 Bifocal – $40 Trifocal – $55	Lenses & Frames **or** Contact Lenses once every per calendar year. Additional benefits available for contacts, bifocals, etc. Out-of-Network charges are reimbursed after claim is submitted.
	Children's dental check-up	Preventive services (2 cleanings, 2 exams, 2 bitewing x-rays per person per year) are covered at no charge; then 20% coinsurance after dental deductible		Limit two dental check-ups per person per Calendar Year. Subject to $2,500 per year individual maximum.

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
- Bariatric surgery
- Cosmetic surgery (unless medically necessary)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (except those covered under ACA preventive care guidelines)

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

- Chiropractic care
- Dental care (Adult benefits same as above)
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

* For more information about limitations and exceptions, see the plan document.

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 Office at (708) 597-1832 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

Para obtener asistencia en Español, llame al (708) 597-1832.

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	$500
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$500
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,370**

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

The plan's overall deductible	$500
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$500
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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