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, go to www.ibew364benefits.org or call 1-877-364-4239. 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.com or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 / individual or $800 / family for in-network; $700 / individual or $1,400 / family for out-of-network services.	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, the family members must meet a cumulative 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. Preventive care services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $500 deductible for hospital admissions not pre-certified. $100 per year deductible for dental.	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?	The aggregate limit is $8,550 for individual / $17,100 for family. The regular limit is $2,000 individual / $4,000 for family.	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. The aggregate includes deductible and prescription drugs.
What is not included in the out-of-pocket limit?	Prescription copay, chiropractic services, out-of-network balance-billing, deductibles and items 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. See www.bcbsil.com or call 1-800-810-2583 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 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	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Specialist visit	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Preventive care/screening/ immunization	No charge	No coinsurance/copay	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. Out-of-network providers may balance bill.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.bcbsil.com/pharmacy**	Generic drugs (Tier 1)	$10 copay for 30 day supply; $20 copay for 31-90 day supply	$10 copay for 30 day supply; $20 copay for 31-90 day supply	Participants choosing Brand when Generic is available, will be responsible for the difference in cost between the Brand and Generic drug. Walmart pharmacies are excluded.
	Preferred brand drugs (Tier 2)	$20 copay for 30 day supply; $40 copay for 31-90 day supply	$20 copay for 30 day supply; $40 copay for 31-90 day supply	
	Non-preferred brand drugs (Tier 3)	$30 copay for 30 day supply; $60 copay for 31-90 day supply plus difference in cost	$30 copay for 30 day supply; $60 copay for 31-90 day supply plus difference in cost	
	Specialty drugs (Tier 4)	Copay will vary based on drug class		Specialty drugs can be generic, preferred or non-preferred drugs. Walmart pharmacies are excluded.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.

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 need immediate medical attention	Emergency room care	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network emergency room paid at in-network if an emergency. Out-of-network providers may balance bill.
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Urgent care	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	Must be pre-certified; not pre-certified $500 penalty.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Services of a counselor are only covered if recommended by a physician (MD). Out-of-network providers may balance bill.
	Inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	
If you are pregnant	Office visits	No charge	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Childbirth/delivery professional services	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Childbirth/delivery facility services	20% coinsurance after deductible	30% coinsurance after deductible	Non-participating facilities are **not** covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	Must be provided by a participating home health care agency; limited to a maximum of 4 hours per day, 60 days per individual per year. Out-of-network providers may balance bill.
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible	Services at non-participating outpatient physical therapy facilities are **not** covered. Out-of-network providers may balance bill.
	Habilitation services	20% coinsurance after deductible	30% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	Must be provided by a participating skilled nursing facility; limited to a maximum of 4 hours per day up to 60 days per individual per calendar year. Out-of-network providers may

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)	
				balance bill.
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	Out-of-network providers may balance bill.
	Hospice services	20% coinsurance after deductible	30% coinsurance after deductible	Provided through a participating hospice program only; terminally ill 6 months or less.
If your child needs dental or eye care	Children's eye exam	Exam covered up to $70.		Limited to one exam per year. Glasses or contacts covered once per individual per calendar year, no deductible.
	Children's glasses	Single vision lens up to $63 per lens; Bifocals-$84, trifocal-$105; frames covered up to $126; Contacts covered up to $252.		
	Children's dental check-up	0% coinsurance for preventive services only		$2,000 maximum benefit per individual per calendar year

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
- Infertility treatment
- Long-term care
- Naprapath services and treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (not medically necessary)
- Weight loss programs

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

- Activate Health & Wellness Centers, this will provide free medical care and prescriptions to eligible individuals
- Chiropractic care
- Dental Implants
- Hearing aids
- Routine dental care (Adult)
- Routine eye care (Adult)

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, Employee Benefits Security Administration 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: www.ibew364benefits.org or 1-877-364-4239. You may also contact the Department of Laborer 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-364-4239.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-364-4239.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-364-4239.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-364-4239.

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	$400
Specialist copayment	20%
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	$400
Copayments	$10
Coinsurance	$1,900
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	$400
Specialist copayment	20%
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*	$100
Copayments	$600
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	$400
Specialist copayment	20%
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*	$400
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

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