




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, see www.chicagolaborerfunds.com or call 1-866-906-0200. 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 or call 1-866-906-0200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For <u>network</u> and non-network <u>providers</u> combined: \$300/Individual or \$600/family Applies on a calendar year basis.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , and certain other medical expenses 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.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>network providers</u> : Maximum of \$750/individual; for non-network <u>providers</u> : Maximum of \$1,500/individual	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, prescription drugs, the <u>deductible</u> , and health care this <u>plan</u> does not 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 <u>network provider</u>?	Yes. See www.bcbil.com or call 1-800-810-2583 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 will pay the most if you use a non-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use a non-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Non-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	10% <u>coinsurance</u> ;	20% <u>coinsurance</u> ;	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>Deductible</u> does not apply	No charge; <u>Deductible</u> does not apply	The <u>plan</u> pays 100% of covered wellness visits, screening, and immunizations for members, spouses, and dependents. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com .	Generic drugs (Tier 1)	\$5 <u>copay</u> /prescription (retail); \$12.50 <u>copay</u> /prescription (mail order) and 20% <u>coinsurance</u> after the Basic Benefit	50% <u>coinsurance</u>	The <u>plan</u> pays for the first \$5,000 per person/year for all prescription drug expenses (“Basic Benefit”). You must pay your <u>copay</u> upfront and then submit it for reimbursement. After the first \$5,000 has been reached, you will no longer be eligible for reimbursement of your <u>copay</u> . If you fill a prescription at a non-network pharmacy, you must pay 100% of the cost and then request reimbursement for 50%. Contraceptives limited to \$500 per year for members and spouses only.
	Preferred brand drugs (Tier 2)	\$10 <u>copay</u> /prescription (retail); \$25.00 <u>copay</u> /prescription (mail order) and 20% <u>coinsurance</u> after the Basic Benefit	50% <u>coinsurance</u>	
	Non-preferred brand drugs (Tier 3)	\$25 <u>copay</u> /prescription (retail); \$62.50 <u>copay</u> /prescription (mail order) and 20% <u>coinsurance</u> after the Basic Benefit	50% <u>coinsurance</u>	
	<u>Specialty drugs</u> (Tier 4)	20% <u>coinsurance</u> up to \$1,000; then no charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Charges based on semi-private room rates.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Charges based on semi-private room rates.
If you are pregnant	Office visits	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Depending on the type of services, <u>deductible</u> may apply. Maternity expenses are covered for dependent children.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage is limited to 180 days/year combined with <u>Skilled Nursing Care</u> .
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to speech therapy for dependent children before 5 th birthday and therapy for special diagnosis before 9 th birthday.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage is limited to 180 days/year combined with <u>Home Health Care</u> .
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	\$25,000 limit on each initial or replacement prosthetic device. Must be standard model ordered by physician. Replacement covered every 5 year for adults and every two years for children under 16.
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Hospice care that extends beyond 365 days per lifetime is excluded.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Routine eye care (Adult & Child)
- Weight loss programs

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

- Acupuncture (By a licensed acupuncturist for pain management)
- Chiropractic care (Back-related care up to \$2,000 per person per year)
- Hearing aids (Up to \$1,500 every 3 calendar years)
- Infertility treatment (\$12,500 lifetime per person; limited to members and spouses only).
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (for Home Health Care only)
- Routine foot care (If medically necessary)

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's Employee Benefits Security Administration at 1-866-444-3272 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 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: Plan Administrator, Chicago Laborers' Welfare Fund, 11465 Cermak Road, Westchester IL 60154, 1-866-906-0200. 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, 320 W. Washington St., 4th Floor, Springfield, IL 62727 at 1-877-527-9431 or www.insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-906-0200.

—————*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 \$300
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$750
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,110

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

- The plan's overall deductible \$300
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$180
What isn't covered	
Limits or exclusions	\$230
The total Joe would pay is	\$710

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

- The plan's overall deductible \$300
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$460

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