




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 undefined 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 <u>deductible</u>?	For <u>in-network providers</u> and <u>out-of-area providers</u> : \$700 per person/ \$2,100 per family/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 <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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 <u>deductible</u>?	Yes, in-network <u>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 <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>in-network providers</u> and <u>out-of-area providers</u> : \$3,500 per person/ \$10,500 per family/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 <u>out-of-pocket limit</u>?	Penalties for failure to obtain pre-authorization, <u>premiums</u> , <u>balance-billing charges</u> , 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 <u>network provider</u>?	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 charge</u> 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 <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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office or clinic</u>	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/screening/immunization</u>	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 services</u> 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 www.rxolutions.com <u>prescription drug coverage</u> is available at www.rxolutions.com	Retail (30-day supply) or Mail (90-day supply)			
	Generic drugs	10% <u>coinsurance</u> , with a \$200 maximum per prescription	Not Covered	\$5,950 per person/\$8,400 per family in-network <u>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	Maintenance drugs must be filled through the OptumRx Mail Service Pharmacy, which covers up to a 90-day supply.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , with	Not Covered	

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	a \$250 maximum per prescription		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 <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$200 <u>copayment</u> per emergency room visit		<u>Copayment</u> waived if admitted to Hospital within 48 hours of treatment.
	Emergency medical transportation	20% <u>coinsurance</u>	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 <u>copayment</u>	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not Covered	Pre-certification required for inpatient and outpatient services; otherwise, you must pay \$500, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . Pre-certification requirement does not apply to office visits.
	Inpatient services			
If you are pregnant	Office visits			<u>Cost sharing</u> does not apply for <u>preventive services</u> . <u>Preventive services</u> are covered at no cost.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	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 <u>deductible</u> or <u>out-of-pocket limit</u> . Limited to 60 visits per calendar year. If not arranged through Case Management Service, you

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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)	
				must pay 30% <u>coinsurance</u> and are limited to 40 visits per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Habilitation services	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> 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 <u>deductible</u> or <u>out-of-pocket limit</u> .
	Durable medical equipment	20% <u>coinsurance</u>	Not Covered	If not arranged through Case Management Services, you must pay 30% <u>coinsurance</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 <u>deductible</u> or <u>out-of-pocket limit</u> .
If your child needs dental or eye care	Children's eye exam	Not Covered		Vision screening for children is covered as <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
- Hearing aids
- Private duty nursing
- Cosmetic surgery (unless performed to correct congenital defect, defects incurred through traumatic injury, or malfunctioning organs)
- Long-term care
- Routine eye care (Adult)
- Dental care (Adult)
- Non-emergency care when traveling outside the United States

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

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

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](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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](#) \$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.