




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 1-708-449-7373. 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.http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.com](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-708-449-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$350</b> individual <b>\$1,050</b> family (maximum of 3 individual deductibles per family per calendar year)	You must pay all the costs up to the <a href="#">deductible</a> amount before this plan begins to pay for covered services you use. The <a href="#">deductible</a> starts over each January 1. See the chart starting on page 2 for how much you pay for covered services after you meet the <a href="#">deductible</a> and for which services are subject to the <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>\$50</b> for dental benefits per person and <b>\$50</b> for prescription drugs per person. There are no other specific <a href="#">deductibles</a> .	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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$2,000</b> per individual for PPO medical. <b>\$2,000</b> individual prescription drugs. <b>\$4,000</b> family prescription drugs.	The <a href="#">out-of-pocket limit</a> is the most you could pay during the coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> , health care services this plan does not cover, <a href="#">deductibles</a> , covered services at non-PPO hospitals and ambulatory surgical facilities or by non-PPO physicians, and <a href="#">copayments</a> for failure to obtain <a href="#">preauthorization</a> for certain services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of participating providers, visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-BLUE (2583) or call	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance</a>

	the Fund Office at 1-708-449-7373.	<a href="#">billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> (in facility) 15% <a href="#">coinsurance</a> (in physician's office)	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> (in facility) 15% <a href="#">coinsurance</a> (in physician's office)	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.express-scripts.com</a>	Generic drugs	30% <a href="#">coinsurance</a> (Retail) 30% <a href="#">coinsurance</a> (Mail)	30% <a href="#">coinsurance</a>	Retail prescription covers up to 34-90 day supply; mail order prescription covers up to 31-90 day supply. Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Brand drugs (when no generic is available)	30% <a href="#">coinsurance</a> (Retail) 30% <a href="#">coinsurance</a> (Mail)	30% <a href="#">coinsurance</a>	
	Brand drugs (when generic is available)	35% <a href="#">coinsurance</a> (Retail) 35% <a href="#">coinsurance</a> (Mail)	35% <a href="#">coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.

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)	
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	20% <a href="#">coinsurance</a> (30% if non-emergency)	None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	30% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Private room covered only if semi-private not available.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	30% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	30% <a href="#">coinsurance</a>	None.
If you are pregnant	Office visits	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	30% <a href="#">coinsurance</a>	Rehabilitative speech therapy to restore normal speech only if lost due to stroke or injury. For functional purposes not covered. <a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
	<a href="#">Habilitation services</a>	Not covered	Not covered	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> (facility) 15% <a href="#">coinsurance</a> (physician)	Not covered	Pre-certification of PPO in-network status required. <a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to services under Hospice Care Program (covered 100%).

[\* For more information about limitations and exceptions, see the plan or policy document at [www.sm73funds.org](http://www.sm73funds.org)]

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)	
	<a href="#">Hospice services</a>	No charge.	No charge.	No <a href="#">deductible</a> or <a href="#">coinsurance</a> applies. 16-day limit for inpatient and 80-day limit for outpatient. Maximum benefit of \$10,000 per person.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge up to \$50	Not subject to <a href="#">deductible</a> .
	Children's glasses	No charge up to \$425 during consecutive two-year period; 20% off balance over \$425	No charge up to \$250	Not subject to <a href="#">deductible</a> .
	Children's dental check-up	No charge.	No charge.	<a href="#">Preventive services</a> at 20% <a href="#">coinsurance</a> . Basic services 40% <a href="#">coinsurance</a> . Major services 60% <a href="#">coinsurance</a> . Dental anesthesia 60% <a href="#">coinsurance</a> . \$50 <a href="#">deductible</a> per year per person applies. Benefit limited to \$1,500 per year per person.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Gene Therapy Treatments and Gene Therapy</li> <li>• Prescription Drugs</li> <li>• Habilitation Services</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing (unless medically necessary)</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Speech therapy (for functional purposes, including, but not limited to: stuttering, stammering, and conditions of psychoneurotic origin, or for developmental speech delays)</li> <li>• Weight loss programs (except as required under <a href="#">preventive services</a> mandate)</li> <li>• Orthodontics</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery (subject to certain conditions)</li> <li>• Chiropractic care (up to 20 visits per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Hearing Aids (up to \$1,250 per device)</li> <li>• Infertility Treatment (50% coinsurance up to \$20,000 per couple per lifetime for treatments of infertility)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>

**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, Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of

Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 the Fund Office at 1-708-449-7373. Additionally, assistance may be provided by your local EBSA office by calling 1-866-444-3272.

**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 1-708-449-2122.

*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 in-network coverage.**

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	30%

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,110</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,300
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	30%

**This EXAMPLE event includes services like:**  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office at 1-708-449-7373.

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.