




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 1-866-844-0488. 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 1-866-844-0488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$200 per person/\$400 per family; <u>Non-Network</u> : \$300 per person/\$600 per family	Generally, you must pay all of the costs from providers 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. <u>Preventive services</u> and office visits with UHS are covered before you meet your <u>deductible</u> , as are <u>prescription drugs</u> and dental/vision services when you use a <u>network provider</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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 per person/\$100 per family for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$2,500 per person/\$5,000 per family; <u>Prescription Drugs</u> : \$3,000 per person/\$6,000 per family <u>Non-Network</u> : \$3,900 per person/\$7,800 per family	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>?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> (called pre-certification <u>deductibles</u>) or provide required notice after ER visit, expenses above any <u>plan</u> limit, chiropractic care, acupuncture, non-surgical TMJ, certain podiatry expenses, dental and vision expenses (which are separately insured), <u>non-network cost sharing</u> (subject to separate limit), <u>prescription drugs</u> (subject to separate limit), certain specialty pharmacy drugs that are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u> , and any services 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.bcbsil.com or call UHS at 1-312-423-4200 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 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</u> charge 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>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 ¹
		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</u> office or clinic	Primary care visit to treat an injury or illness	No charge at UHS and <u>deductible</u> does not apply; 20% <u>coinsurance</u> with <u>referral</u> for non-UHS	30% <u>coinsurance</u> with UHS <u>referral</u>	None
	<u>Specialist</u> visit	No charge at UHS and <u>deductible</u> does not apply; 20% <u>coinsurance</u> with <u>referral</u> for non-UHS	30% <u>coinsurance</u> with UHS <u>referral</u>	You pay 50% for chiropractic, acupuncture and non-surgical temporomandibular (TMJ) treatment with UHS <u>referral</u> ; <u>plan</u> pays up to \$1,000 per person per year for all expenses combined (<u>network</u> and <u>non-network</u> combined). You pay 50% <u>coinsurance</u> for podiatry expenses with UHS <u>referral</u> . <u>Plan</u> pays up to \$1,000 per person per year for podiatry services (<u>network</u> and <u>non-network</u> combined); limit does not apply to podiatry expenses related to, and incurred within 48 hours of, an accident; for removal of nail roots; or for care prescribed by a physician treating metabolic or peripheral vascular disease. You pay <u>20% coinsurance</u> for podiatry expenses that result from and are incurred within 48 hours of an accidental injury.
	<u>Preventive care/screening/immunization</u>	No charge at UHS. <u>Deductible</u> does not apply.	30% <u>coinsurance</u> with UHS <u>referral</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.

¹ Unless otherwise provided, a UHS referral is required for all services provided outside of UHS.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information ¹
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge at UHS; 20% <u>coinsurance</u> with <u>referral</u> for non-UHS	30% <u>coinsurance</u> with UHS <u>referral</u>	None
	Imaging (CT/PET scans, MRIs)	No charge at UHS; 20% <u>coinsurance</u> with <u>referral</u> for non-UHS	30% <u>coinsurance</u> with UHS <u>referral</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.express-scripts.com</u> or call 1-888-397-0627.	Generic drugs	20% <u>coinsurance</u> with a \$10 minimum for retail after \$50 <u>deductible</u> ; 20% <u>coinsurance</u> with a \$20 minimum and \$40 maximum for mail order.	Not covered	The medical <u>deductible</u> and <u>out-of-pocket limit</u> do not apply to <u>prescription drugs</u> . There is a separate \$50 per person/\$100 per family <u>deductible</u> for <u>prescription drugs</u> . There is a separate <u>out-of-pocket limit</u> for covered <u>prescription drugs</u> . You may obtain up to a 30-day supply at retail or a 90-day supply at network retail pharmacies or through mail order. After an initial fill at retail and one refill, you must either use a <u>network</u> retail pharmacy or use the mail order program for maintenance medications.
	Preferred brand drugs	20% <u>coinsurance</u> with a \$25 minimum for retail after \$50 <u>deductible</u> ; 20% <u>coinsurance</u> with a \$50 minimum and \$100 maximum for mail order plus the difference between generic and brand name drug when doctor allows substitution.	Not covered	
	Non-preferred brand drugs	20% <u>coinsurance</u> with a \$40 minimum for retail; 20% <u>coinsurance</u> with an \$80 minimum and \$160 maximum for mail order plus the difference between generic and brand name drug when doctor allows substitution.	Not covered	No charge for FDA-approved generic contraceptives or other ACA-required preventive drugs. Brand drugs are covered at no charge if a generic is medically inappropriate. Step therapy applies to some <u>prescription drugs</u> .
	<u>Specialty drugs</u>	20% <u>coinsurance</u> with a \$100 minimum and a \$250 maximum.	Not covered	Certain medications may be obtained only through the Accredo Specialty Pharmacy. Visit <u>www.accredo.com</u> or call 1-800-803-2523.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information ¹
		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)	20% <u>coinsurance</u> with UHS <u>referral</u>	Not covered	\$250 non- <u>preauthorization deductible</u> if you don't call to preauthorize with Med-Care Management (MCM) at 1-800-845-7348.
	Physician/surgeon fees	20% <u>coinsurance</u> with UHS <u>referral</u>	Not covered	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> for <u>emergency medical condition</u> ; otherwise, 50% <u>coinsurance</u>	20% <u>coinsurance</u> for <u>emergency medical condition</u> ; otherwise, 50% <u>coinsurance</u>	\$250 penalty if you don't notify MCM at 1-800-845-7348 and UHS at 1-312-423-4200 within 48 hours of the visit. <u>Network deductible</u> and <u>non-network out-of-pocket limit</u> apply to <u>non-network emergency room care</u> for <u>emergency medical condition</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> with UHS <u>referral</u> for ground and air ambulance	30% <u>coinsurance</u> with UHS <u>referral</u> for ground and air ambulance	Air ambulance services are covered only when the <u>plan</u> determines they are <u>medically necessary</u> . <u>Preauthorization</u> by MCM (1-800-845-7348) and UHS (1-312-423-4000) is required for non-emergency air ambulance services or coverage will be denied.
	<u>Urgent care</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate.
	Physician/surgeon fees	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge at UHS and <u>deductible</u> does not apply; 20% <u>coinsurance</u> for non-UHS (no <u>referral</u> needed)	30% <u>coinsurance</u> (no <u>referral</u> needed)	None
	Inpatient services	20% <u>coinsurance</u> (no UHS <u>referral</u> needed)	30% <u>coinsurance</u> (no <u>referral</u> needed)	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348. Coverage based on semi-private room rate.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information ¹
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge with UHS; 20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive <u>screenings</u>) not covered for dependent children.
	Childbirth/delivery professional services	No charge with UHS; 20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	Coverage based on semi-private room rate. \$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348 if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery facility services	No charge with UHS; 20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	Not covered for dependent children.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.
	<u>Habilitation services</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	Up to 90 days per person per year (<u>network</u> and <u>non-network</u> combined); \$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM at 1-800-845-7348 to preauthorize purchase over \$500 or rental. <u>Plan</u> pays up to \$10,000 per person per year for benefits that are not essential health benefits under ACA. <u>Plan</u> pays up to \$25,000 per prosthesis every 5 years.
	<u>Hospice services</u>	20% <u>coinsurance</u> with UHS <u>referral</u>	30% <u>coinsurance</u> with UHS <u>referral</u>	\$250 non- <u>preauthorization deductible</u> if you don't call MCM to preauthorize at 1-800-845-7348.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information ¹
		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	Based on schedule. <u>Deductible</u> does not apply.	Not covered	Separately insured by EyeMed. Must use EyeMed <u>provider</u> ; exam/glasses up to once every 12-month period.
	Children's glasses	Discounts only. <u>Deductible</u> does not apply.	Not covered	
	Children's dental check-up	Based on schedule. <u>Deductible</u> does not apply.	Not covered	Separately insured by BlueCare Dental HMO. Must use Blue Care Dental HMO dentist.

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.)

- Cosmetic surgery
- Infertility treatment (except for standard fertility preservation services provided by UHS)
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by ACA)

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

- Acupuncture (50% coinsurance with UHS referral)
- Bariatric surgery (Limited to once per person per lifetime, preauthorization required and excludes dependent children)
- Chiropractic care (50% coinsurance with UHS referral)
- Dental care (Adult) (Provided by Blue Care Dental HMO, call 1-866-431-1601)
- Hearing aids (up to \$1,000 per person in 3-year period, \$500 per ear)
- Non-emergency care when traveling outside the U.S. (paid as out-of-network with \$250 non-preauthorization deductible)
- Routine eye care (Adult) (Provided by EyeMed, call 1-866-723-0514)
- Routine foot care (50% coinsurance with UHS referral)

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 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 1-866-844-0488 or call UHS at 1-312-423-4200 regarding medical claims. 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 1-877-527-9431 or DOI.Director@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 1-866-844-0488.

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 <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$210*
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$270

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$170
Copayments	\$0
Coinsurance	\$1,030
What isn't covered	
Limits or exclusions	\$230
The total Joe would pay is	\$1,430

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$210*
Copayments	\$0
Coinsurance	\$420
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$630

***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.