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.pf597.org or call 1-312-633-0597. 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 http://www.healthcare.gov/sbc-glossary or call 1-312-633-0597 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person/**$1,500** per family per calendar year.	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**, each family member must meet their own individual **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. PPO **preventative care**, children's eye exams and children's preventive dental care 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$1,950** per person/**$5,850** per family (PPO); **$5,000** per person (Non-PPO).	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in the **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Certain Non-PPO expenses; dental/vision payments; **prescription drug copayments**; **premiums**; **balance-billing** charges; and health care 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 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	15% **coinsurance**	25% **coinsurance**	Telemedicine is a covered benefit. Check the **plan** for coverage levels.
	Specialist visit	15% **coinsurance**	25% **coinsurance**	Spinal manipulation and naprapathy services limited to 20 visits per person per calendar year. No benefits are payable for persons under age 16.*
	Preventive care/screening/ immunization	No charge; **deductible** does not apply	25% **coinsurance**	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.
If you have a test	Diagnostic test (x-ray, blood work)	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Imaging (CT/PET scans, MRIs)	15% **coinsurance**	25% **coinsurance**	----------none----------*
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com.		**Retail** / **Mail**		
	Generic drugs	\$10 **copay**/fill / \$20 **copay**/fill	Cost of medicine in excess of what the **Plan** normally pays for that prescription plus the applicable **copayment** under the PPO.	**\$5,000** per person/**\$5,000** per family per calendar year **out-of-pocket maximum** (excludes prescription narcotics and charges for **specialty drugs** under the **Copayment** Assistance Program).* Retail prescriptions limited to 34-day supply; mail order prescriptions limited to 90-day supply.
	Preferred brand drugs	20% **coinsurance** (\$25 min) / 20% **coinsurance** (\$50 min)		
	Non-preferred brand drugs	30% **coinsurance** (\$45 min) / 30% **coinsurance** (\$90 min)		
	Specialty drugs	Retail or mail order **copayments** apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Physician/surgeon fees	15% **coinsurance**	25% **coinsurance**	----------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)	
If you need immediate medical attention	Emergency room care	15% **coinsurance**	15% **coinsurance**	----------none----------*
	Emergency medical transportation	15% **coinsurance**	25% **coinsurance** for ground ambulance 15% **coinsurance** for air ambulance	----------none----------*
	Urgent care	15% **coinsurance**	25% **coinsurance**	----------none----------*
If you have a hospital stay	Facility fee (e.g., hospital room)	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Physician/surgeon fees	15% **coinsurance**	25% **coinsurance**	----------none----------*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Inpatient services	15% **coinsurance**	25% **coinsurance**	----------none----------*
If you are pregnant	Office visits	15% **coinsurance**	25% **coinsurance**	**Cost sharing** does not apply for **preventive services**. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	15% **coinsurance**	25% **coinsurance**	
	Childbirth/delivery facility services	15% **coinsurance**	25% **coinsurance**	

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 help recovering or have other special health needs	Home health care	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Rehabilitation services	15% **coinsurance**	25% **coinsurance**	Coverage for outpatient speech/physical therapy subject to utilization review and limited to 40 visits per person per calendar year (combined total); occupational therapy subject to utilization review and limited to 40 visits per person per calendar year. After 40 visits, 25% **coinsurance** applies.*
	Habilitation services	15% **coinsurance**	25% **coinsurance**	Coverage limited to expenses provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical conditions of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses.*
	Skilled nursing care	15% **coinsurance**	25% **coinsurance**	Limited to 60 days per person per confinement; confinement must begin within 14 days after a Hospital admission of at least 3 days.*
	Durable medical equipment	15% **coinsurance**	25% **coinsurance**	----------none----------*
	Hospice services	15% **coinsurance**	25% **coinsurance**	Must be rendered as part of a hospice care program by a licensed hospice care agency.*

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 your child needs dental or eye care	Children's eye exam	No charge; **deductible** does not apply	No charge; **deductible** does not apply	Limited to one exam per person per calendar year.*
	Children's glasses	80% of balance over $150 for frames; no charge for standard plastic lenses	Balance over $110 for frames, lenses and options	Limited to one frame and/or one pair of lenses per person per calendar year.*
	Children's dental check-up	No charge; **deductible** does not apply	No charge; **deductible** does not apply	No charge for preventive and diagnostic services, but the annual dental benefit maximum of $2,500 will apply for all other covered services. *

***** Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA.

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 (unless you are at least 100 pounds or more above your ideal weight; you are considered morbidly obese; and surgery is determined by the Fund to be **Medically Necessary**)
- Cosmetic Surgery (except for repair of congenital defects of your Dependent child; for the repair of defects resulting from a surgery, Accident or illness as defined by the **Plan**; or for conditions resulting from accidental injuries, scars, tumors or diseases that occur)
- Long-term care
- Private-duty nursing

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

- Acupuncture
- Chiropractic care (limited to 20 visits per person per calendar year; no benefits are payable for persons under age 16)
- Dental care (Adult) ($2,500 maximum benefit per person per calendar year)
- Hearing aids (No charge up to $2,000 per ear; limited to one hearing aid per ear for any 36 consecutive month period)
- Infertility treatment (Participant and Dependent spouse only; $20,000 per lifetime medical maximum and $10,000 per lifetime **prescription drug** maximum)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (as provided under the **Plan** – member and Dependent spouse only)

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 Benefit 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 Department of Labor's Employee Benefit 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 1-312-633-0597.

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	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$500
Copayments	$10
Coinsurance	$1,450
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,020**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$500
Copayments	$310
Coinsurance	$720
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,550**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	$500
Copayments	$10
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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

* For more information about limitations and exceptions, see the plan or policy document at www.pf597.org