



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 1-312-633-0597 or visit www.pf597.org. 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 1-312-633-0597 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$600 per person/\$1,800 per family per calendar year.	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. PPO <u>preventive care</u> and children's preventive dental care 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 preventive services 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> ?	\$5,000 per person for PPO expenses; \$10,000 per family for PPO expenses.	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> ?	Non-PPO expenses; <u>prescription drug copayments</u> ; <u>premiums</u> ; <u>balance-billing</u> charges; 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. See www.bcbst.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 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Telemedicine is a covered benefit. See the <u>plan</u> for coverage levels.	
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Spinal manipulation and naprapathy services limited to 20 visits per person per calendar year. No benefits are payable for persons under age 16.	
	<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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.cvscaremark.com		Retail	Mail		
	Generic drugs	40% <u>coinsurance</u> (\$5 min)	40% <u>coinsurance</u> (\$10 min)	Cost of medicine in excess of what the <u>Plan</u> normally pays for that prescription plus the applicable <u>copayment</u> under the PPO.	\$4,200 per person/\$8,400 per family <u>out-of-pocket maximum</u> per year (excludes prescription narcotics).
	Preferred brand drugs	40% <u>coinsurance</u> (\$15 min)	40% <u>coinsurance</u> (\$30 min)		Retail prescriptions limited to 34-day supply; mail order prescriptions limited to 90-day supply.
	Non-preferred brand drugs	40% <u>coinsurance</u> (\$30 min)	40% <u>coinsurance</u> (\$60 min)		40% <u>coinsurance</u> for prescription narcotics; not subject to any <u>out-of-pocket maximum</u> .
	<u>Specialty drugs</u>	40% <u>coinsurance</u>			

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

Page 2 of 7

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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> for ground ambulance 20% <u>coinsurance</u> for air ambulance	
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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, 40% <u>coinsurance</u> applies.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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, multiple or complicated fractures, spinal cord injuries, other severe diagnoses with neurological implications, and significant or multiple injuries and/or illnesses.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per person per confinement; confinement must begin within 14 days after a Hospital admission of at least 3 days.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----

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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)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for vision care.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	No charge for preventive and <u>diagnostic services</u> , but the annual dental benefit maximum of \$2,000 will apply for all other covered services. *

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)
- Hearing Aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and Child)
- Weight loss programs (except as required by health reform law)

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) (\$2,000 maximum benefit per person per calendar year)
- 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 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 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](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.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 Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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.

Pennsylvania Dutch (Deitsch): Fer Hilf grieg in Deitsch, ruf 1-312-633-0597 uff.

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	\$600
■ Specialist coinsurance	20%
■ 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:	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$2,330
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,990

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$600
■ Specialist coinsurance	20%
■ 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:	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$1,850
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,470

Mia's Simple Fracture

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

■ The plan's overall deductible	\$600
■ Specialist coinsurance	20%
■ 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:	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,040

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