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.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 preventive 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: 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. See 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----------	
If you need immediate	Emergency room care	15% coinsurance	15% 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)	
medical attention	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 is subject to utilization review and limited to 40 visits per person per calendar year (combined total); occupational therapy is 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, multiple or complicated fractures, spinal cord injuries, other severe diagnoses with neurological implications, and 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.

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 every three years)
- 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, except as required by health reform law)

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.

Pennsylvania Dutch (Deitsch): Fer Hilf griege 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	$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.