




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, go to [www.silehw.org](http://www.silehw.org) or call (618) 998-1300. 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 <https://www.healthcare.gov/sbc-glossary/> or call (618) 998-1300 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network</a> : \$850 per Individual/\$2,550 per Family <a href="#">Out-of-Network</a> : \$4,000 per Individual/\$12,000 per Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">In-Network Preventive</a> , Hearing, Smoking Cessation, Vision and <a href="#">Prescription</a> Benefits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> 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 <a href="#">plan</a> covers certain <a href="#">in-network preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$50 Dental <a href="#">deductible</a> ,	You must pay all the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical <a href="#">In-Network</a> : \$5,250 per Individual/\$10,500 per Family Pharmacy <a href="#">In-Network</a> : \$1,900 per Individual/\$3,800 per Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall the family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call (800) 624-2356 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance 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> .
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 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
		In-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	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	TELEHEALTH or VIRTUAL VISITS:  With an MDLIVE Provider, no <a href="#">deductible</a> or <a href="#">coinsurance</a> .  With an IN-NETWORK, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% <a href="#">coinsurance</a>  With an OUT-OF-NETWORK Provider (Neither MDLIVE nor BCBS), 55% <a href="#">coinsurance</a>
	<a href="#">Specialist</a> visit			-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	55% <a href="#">coinsurance</a>	<a href="#">In-Network</a> – No <a href="#">deductible</a> . Limited to 1 physical exam (including, but not limited to, pap smear, gynecological exam and prostate exam) per calendar year. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. For specific benefits and limitations, see Article 7 of the SPD.*
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)			

\*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available by calling the Fund Office at (618) 998-1300.	Generic <a href="#">drugs</a>	Retail (30 days) – Greater of \$10 or 25% <a href="#">coinsurance</a> , \$20 max  Mail order (90 days) - Greater of \$20 or 25% <a href="#">coinsurance</a> , \$50 max	Not covered	No <a href="#">deductible</a> on <a href="#">Prescription</a> Benefits.  If a participant chooses to utilize a brand <a href="#">drug</a> when a generic equivalent is available, the participant will be required to pay the applicable \$40 or \$70 <a href="#">copayment</a> plus the difference in cost between the brand <a href="#">drug</a> and generic.
	Preferred brand <a href="#">drugs</a>	Retail (30 days) – Greater of \$35 or 30% <a href="#">coinsurance</a> , \$40 max  Mail order (90 days) - Greater of \$70 or 30% <a href="#">coinsurance</a> , \$75 max		
	Non-preferred brand <a href="#">drugs</a>	Retail (30 days) – Greater of \$45 or 35% <a href="#">coinsurance</a> , \$70 max  Mail order (90 days) - Greater of \$90 or 35% <a href="#">coinsurance</a> , \$100 max		
	<a href="#">Specialty drugs</a>	SPECIALTY PHARMACY 30% <a href="#">coinsurance</a> , \$225 max per <a href="#">prescription</a>  PHYSICIAN OR FACILITY 30% <a href="#">coinsurance</a> , \$225 max per course of treatment, subject to <a href="#">deductible</a> .	Not covered	Cancer related <a href="#">drugs</a> are excluded from the 30% <a href="#">coinsurance</a> . The first dialysis treatment of each month that includes bio-injectable or specialty medications is subject to \$225 <a href="#">copayment</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after \$175 <a href="#">copayment</a> /visit for non-accidents		\$175 <a href="#">copayment</a> /visit waived if patient is immediately admitted to hospital.
	<a href="#">Emergency medical transportation</a>			-----none-----
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	<p>TELEHEALTH or VIRTUAL VISITS:</p> <p>With an MDLIVE Provider, no <a href="#">deductible</a> or <a href="#">coinsurance</a>.</p> <p>With an IN-NETWORK, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% <a href="#">coinsurance</a>.</p> <p>With an OUT-OF-NETWORK Provider (Neither MDLIVE nor BCBS), 55% <a href="#">coinsurance</a>.</p>
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	Semi-private room only.
	Physician/surgeon fees			-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	<p>TELEHEALTH or VIRTUAL VISITS:</p> <p>With an MDLIVE Provider, no <a href="#">deductible</a> or <a href="#">coinsurance</a>.</p> <p>With an IN-NETWORK, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% <a href="#">coinsurance</a>.</p> <p>With an OUT-OF-NETWORK Provider (Neither MDLIVE nor BCBS), 55% <a href="#">coinsurance</a>.</p>
	Inpatient services			-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	Post-natal services, delivery and inpatient services for Employee and Spouse only. <a href="#">Cost sharing</a> does not apply to <a href="#">in-network preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or a <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	55% <a href="#">coinsurance</a>	Limit of 100 visits per calendar year. Up to 4 hours = 1 visit.
	<a href="#">Rehabilitation services</a>			Limit of 50 combined visits per year for speech, occupational and physical therapy. Speech therapy covered only for certain conditions. See SPD Section 2.22 for more information.*
	<a href="#">Habilitation services</a>			Limit of 50 combined visits per year for speech, occupational and physical therapy See Article 7 of the SPD for other exclusions and limitations.*
	<a href="#">Skilled nursing care</a>			Limit of 30 days per year.
	<a href="#">Durable medical equipment</a>			Wheelchair paid at 50% up to \$1,000. All other <a href="#">equipment</a> rental covered up to the purchase price. See SPD Section 2.09 for criteria.*
	<a href="#">Hospice services</a>			Limit of 185 days per year. Must submit a <a href="#">Hospice</a> Care Plan
If your child needs dental or eye care	Children's eye exam	No charge		Includes 1 routine eye exam each year up to \$100.
	Children's glasses			Includes 1 set of frames and lenses or contacts up to \$150 per year.
	Children's dental check-up			One exam and cleaning every 6 months.

\*For more information about limitations and exceptions, see summary plan description (SPD).

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery (unless necessary as a result of an accident)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Weight loss programs</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>• Chiropractic care (up to 20 visits/year)</li><li>• Dental care (adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Routine eye care (adult)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call (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 (618) 998-1300 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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:

Para obtener asistencia en Español, llame al (618) 998-1300.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$850
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$850
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,220</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>	\$850
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$850
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,470</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>	\$850
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$850
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>