**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.silehw.org or call1-618-998-1300. 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 http://www.dol.gov/esbsa/healthreform or call 1-618-998-1300 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $850 per Individual/$2,550 per Family<br>Out-of-Network: $4,000 per Individual/$12,000 per Family | 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. In-Network Preventive, MD Live Provider, Hearing, Smoking Cessation, Vision and Prescription Benefits 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 in-network 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?** | Yes. $50 Dental deductible. There are no other specific deductibles. | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical In-Network: $5,250 per Individual/$10,500 per Family<br>Pharmacy In-Network: $1,900 per Individual/$3,800 per Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this 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?** | Premiums, balance-billing charges, penalties for failure to obtain precertification, penalties for utilization of emergency room care for non-emergencies, 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. www.bcbsil.com or call 1-800-624-2356 for a list of network providers. | This plan uses a provider network. You pay less if you use a provider in the plan's network. You will pay more 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 |
|---|---|---|---|---|
| | | In-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% coinsurance | 55% coinsurance | **Telehealth or Virtual Visits**<br>With an MDLIVE Provider, no deductible or coinsurance.<br>With an In-Network Provider, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% coinsurance<br>With an Out-of-Network Provider, (Neither MDLIVE nor BCBS), 55% coinsurance |
| | Specialist visit | 20% coinsurance | 55% coinsurance | None |
| | Preventive care/screening/ immunization | No charge | 55% coinsurance | In-Network – No deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. |
| **If you have a test** | Diagnostic test (x-ray, blood work)<br>Imaging (CT/PET scans, MRIs) | 20% coinsurance | 55% coinsurance | None |

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) | |
| **If you need drugs to treat your illness or condition**<br>**More information about prescription drug coverage is available by calling the Fund Office at (618) 998-1300.** | Generic drugs | Retail (30 days) – Greater of $10 or 25% coinsurance, $20 max<br>Mail order (90 days) – Greater of $20 or 25% coinsurance, $50 max | Not covered | No deductible on Prescription Benefits.<br>If a participant chooses to utilize a brand drug when a generic equivalent is available, the participant will be required to pay the applicable $40 or $70 copayment plus the difference in cost between the brand drug and generic. |
| | Preferred brand drugs | Retail (30 days) – Greater of $35 or 30% coinsurance, $40 max<br>Mail order (90 days) – Greater of $70 or 30% coinsurance, $75 max | | |
| | Non-preferred brand drugs | Retail (30 days) – Greater of $45 or 35% coinsurance, $70 max<br>Mail order (90 days) – Greater of $90 or 35% coinsurance, $100 max | | |
| | Specialty drugs | Specialty Pharmacy 30% coinsurance, $225 max per prescription<br>Physician or Facility 30% coinsurance, $225 max per course of treatment, subject to deductible. | | Cancer related drugs are excluded from the 30% coinsurance. The first dialysis treatment of each month that includes bio-injectable or specialty medications is subject to $225 copayment. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 55% coinsurance | Precertification required for outpatient hospital procedures or no coverage. |
| | 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** | Emergency room care | 20% coinsurance after $175 copayment/visit for non-accidents | | $175 copayment/visit waived if patient is immediately admitted to the hospital |
| | Emergency medical transportation | 20% coinsurance | 55% coinsurance; except 20% coinsurance for air ambulance services | None |
| | Urgent care | | 55% coinsurance | **Telehealth or Virtual Visits**<br>With an MDLIVE Provider, no deductible or coinsurance.<br>With an In-Network Provider, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% coinsurance<br>With an Out-of-Network Provider, (Neither MDLIVE nor BCBS), 55% coinsurance |
| **If you have a hospital stay** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 55% coinsurance | Semi-private room only. Precertification required for inpatient hospital admissions or benefits reduced by $500. |
| | Physician/surgeon fees | | | Precertification required for inpatient hospital admissions or benefits reduced by $500. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 55% coinsurance | **Telehealth or Virtual Visits**<br>With an MDLIVE Provider, no deductible or coinsurance.<br>With an In-Network Provider, BCBS Provider (Not MDLIVE or traditionally servicing in person), 20% coinsurance<br>With an Out-of-Network Provider, (Neither MDLIVE nor BCBS), 55% coinsurance |
| | Inpatient services | | | Precertification required for inpatient hospital admissions or benefits reduced by $500. |

| 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% coinsurance | 55% coinsurance | Post-natal services, delivery and inpatient services for Employee and Spouse only. Cost sharing does not apply to in-network preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Precertification required for inpatient hospital admissions or benefits reduced by $500 but only if admission exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section. |
| | Childbirth/delivery facility services | | | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 55% coinsurance | Limit of 100 visits per calendar year. Up to 4 hours = 1 visit. |
| | Rehabilitation services | | | 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.* |
| | Habilitation services | | | Limit of 50 combined visits per year for speech, occupational and physical therapy See Article 7 of the SPD for other exclusions and limitations.* |
| | Skilled nursing care | | | Limit of 30 days per year. |
| | Durable medical equipment | | | Wheelchair paid at 50% up to $1,000. All other durable medical equipment rental covered up to the purchase price. See SPD Section 2.09 for criteria.* |
| | Hospice services | | | Limit of 185 days per year. Must submit a Hospice Care Plan. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Includes 1 routine eye exam each year up to $100. |
| | Children's eyeglasses | | | 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. Annual limit does not apply. |

*For more information about limitations and exceptions, see SPD.

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (unless necessary as a result of an accident)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs (except as required under the health reform law)

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

- Chiropractic care (up to 20 visits/year)
- Dental care (adult) (limited to $1,000/person per year)
- Hearing aids (limited to $500/device per year; once every 5 years)
- Routine eye care (adult) (limited to $200/person per year)
- 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: the U.S. Department of Labor's 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 (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.

**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 (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)

850

- **The plan's overall deductible** **$850**
- **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $850 |
| Copayments | $0 |
| Coinsurance | $2,280 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,190** |

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

- **The plan's overall deductible** **$850**
- **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $850 |
| Copayments | $0 |
| Coinsurance | $1,160 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Joe would pay is** | **$2,080** |

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

- **The plan's overall deductible** **$850**
- **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $850 |
| Copayments | $180 |
| Coinsurance | $360 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,390** |

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