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, 1-877-478-4542 or visit www.ibew150benefis.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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 / individual; $2,250 / 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. Preventive care, dental, vision and prescription drugs 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?	Yes. $300 per emergency room visit and $25 / individual or $50 / family for dental.	You must pay all of 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: $3,000 / individual; $9,000 / family per calendar year. ACA: $8,150 / individual; $16,300 / family per calendar year (includes medical, dental, vision and prescription drugs).	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. The ACA limit increases each calendar year based on the IRS indexed increases.
What is not included in the out-of-pocket limit?	Premiums, out-of-network balance billing and health care this plan doesn't cover. Out-of-Network services are not included in the ACA OOP limit.	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 1-800-571-1043 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 will 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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance	30% coinsurance	None.
	Specialist visit	20% coinsurance	30% coinsurance	Maximum $1,500 per year payable for chiropractic visits.
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% 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)	20% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-866-233-4239	Generic drugs	Retail: greater of 20% of cost or $10, but no more than $35. Mail Order: greater of 20% of cost or $30, but no more than $70.	Greater of 20% of cost or $10, but no more than $35 (retail only).	Deductible does not apply; retail drugs limited to a 30 day supply; mail order drugs limited to a 90 day supply; maintenance medications in 90-day supply must be filled using Sav-Rx prescription delivery mail order service; generic, when available, will be substituted for brand name if doctor has not indicated "dispense as written"; specialty drugs must be filled using Sav-Rxs Specialty pharmacy.
	Brand drugs	Retail: greater of 20% of cost or $25, but no more than $100 ($250 for specialty drugs). Mail Order: greater of 20% of cost or $75, but no more than $150.	Greater of 20% of cost or $25, but no more than $100 (retail only).	

* For more information about limitations and exceptions, see the plan or policy document at www.ibew150benefits.org.

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% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$300 deductible per visit waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	30% coinsurance	None.
	Urgent care	20% coinsurance	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None.
	Inpatient services	20% coinsurance	30% coinsurance	
If you are pregnant	Office visits	20% coinsurance	30% 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	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	None.
	Rehabilitation services	20% coinsurance	30% coinsurance	None.
	Habilitation services	20% coinsurance	30% coinsurance	None.
	Skilled nursing care	20% coinsurance	30% coinsurance	None.
	Durable medical equipment	20% coinsurance	30% coinsurance	None.
	Hospice services	20% coinsurance	30% coinsurance	Coverage available only for 6 months or less to live.

* For more information about limitations and exceptions, see the plan or policy document at www.ibew150benefits.org.

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 every 12 months.
	Children's glasses	No charge; deductible does not apply.	No charge; deductible does not apply.	Limited to one item every 24 months.
	Children's dental check-up	No charge (preventive services only); deductible does not apply.	No charge (preventive services only); deductible does not apply.	Coverage limited to 4 visits per year.

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 to repair a birth defect; damage due to an accident incurred while you are a Covered Person, but no later than two years after the date of the accident, or as required by law
- Long-term care
- Private-duty nursing
- Routine foot care, if not medically necessary
- Weight loss programs

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

- Chiropractic care, $1,500 per year
- Dental care (Adult), $1,500 per year
- Hearing aids, $1,000 / 3 years (paid at 50%)
- Infertility treatment, $12,000 lifetime benefit, prescription drugs are limited to $3,000 per year
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) $350 / year for glasses/contacts

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 Employees 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 plan at 1-877-478-4542. You may also contact the U.S. Department of Labor, 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 1-877-478-4542

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	**$750**
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	$750
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,210**

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

The plan's overall deductible	**$750**
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*	$750
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,670**

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

The plan's overall deductible	**$750**
Emergency room deductible	**$300**
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*	$1,050
Copayments	$0
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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The Plan includes a health reimbursement account (the WRA) that eligible participants can use to pay deductibles, copayments and coinsurance amounts and excluded services under the plan. You may file for reimbursement for some of these expenses. See your SPD for more information.

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