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, see www.chicagolaborerfunds.com or call 1-800-866-906-0200. 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 1-866-906-0200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network and non-network providers combined: $200/Individual or $400/Family Applies on a calendar year basis.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and certain medical expenses are covered before you must meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. A copayment or coinsurance may apply.
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?	For network providers: Maximum of $750/individual; for non-network providers: Maximum of $1,500/individual Applies on a calendar year basis	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, prescription drugs, the deductible, and health care this plan does not 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.bcbil.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 will pay the most if you use a non-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 a non-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)	Non-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	10% coinsurance	20% coinsurance	Telehealth may be available depending on your provider.
	Specialist visit	10% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible does not apply	No charge; Deductible does not apply	The plan pays 100% of covered wellness visits, screening, and immunizations for members, spouses, and dependents. 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)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% 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)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs (Tier 1)	$5 copay/prescription (retail); $10 copay/prescription (CVS mail order); $12.50 copay/prescription (non-CVS mail order) and 20% coinsurance after the Basic Benefit	50% coinsurance	The plan pays the first $5,000 per person/year for all prescription drug expenses ("Basic Benefit"). You must pay your copay upfront and then submit it for reimbursement. After the first $5,000 has been reached, you will no longer be eligible for reimbursement of your copay. If you fill a prescription at a non-network pharmacy, you must pay 100% of the cost and then request reimbursement for 50%. Contraceptives limited to members and spouses only. Your cost sharing does not count toward the out-of-pocket limit.
	Preferred brand drugs (Tier 2)	$10 copay/prescription (retail); $20 copay/prescription (CVS mail order); $25 copay/prescription (non-CVS mail order) and 20% coinsurance after the Basic Benefit	50% coinsurance	
	Non-preferred brand drugs (Tier 3)	$25 copay/prescription (retail); $50 copay/prescription (CVS mail order); $62.50 copay/prescription (non-CVS mail order) and 20% coinsurance after the Basic Benefit	50% coinsurance	
	Specialty drugs (Tier 4)	20% of the cost up to $1,000; then no charge	Not covered	Your cost sharing does not count toward the out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	20% coinsurance	None
	Emergency medical transportation	10% coinsurance	20% coinsurance	
	Urgent care	10% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Charges based on semi-private room rates.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	Telehealth may be available depending on your provider.
	Inpatient services	10% coinsurance	20% coinsurance	Charges based on semi-private room rates.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Depending on the type of services, deductible may apply. Maternity expenses are covered for dependent children.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Coverage is limited to 180 days/year combined with Skilled Nursing Care.
	Rehabilitation services	10% coinsurance	20% coinsurance	None
	Habilitation services	10% coinsurance	20% coinsurance	Limited to speech therapy for dependent children before 5th birthday and therapy for special diagnosis before 9th birthday.
	Skilled nursing care	10% coinsurance	20% coinsurance	Coverage is limited to 180 days/year combined with Home Health Care.
	Durable medical equipment	10% coinsurance	20% coinsurance	$25,000 limit on each initial or replacement prosthetic device. Must be standard model ordered by physician. Replacement covered every 5th year for adults and every two years for children under age 26.
	Hospice services	10% coinsurance	20% coinsurance	Hospice care that extends beyond 365 days per lifetime is excluded.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per calendar year for children over age 15 and under age 18.
	Children's glasses	No charge	No charge up to allowance	Network: lenses at no charge and frames up to $75; 20% off balance over $75. Non-network lenses at various allowances and frames up to $75.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network.

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
- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Weight loss programs

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

- Acupuncture (By a licensed acupuncturist for pain management)
- Chiropractic care (Back-related care up to $2,000 per person per year)
- Hearing aids (Up to $1,500 every 3 calendar years)
- Infertility treatment ($12,500 lifetime limit per person; limited to members and spouses only).
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (for Home Health Care only)
- Routine eye care (Adult)
- Routine foot care (If medically necessary)

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 1-866-444-3272 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 the 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: Plan Administrator, Chicago Laborers' Welfare Fund, 11465 West Cermak Road, Westchester IL 60154, 1-866-906-0200. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington St., 4th Floor, Springfield, IL 62767 at 1-877-527-9431 or www.insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-906-0200.

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.

■ **The plan's overall deductible**	**$200**
■ **Specialist coinsurance**	**10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,010**

■ **The plan's overall deductible**	**$200**
■ **Specialist coinsurance**	**10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$190
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$620**

■ **The plan's overall deductible**	**$200**
■ **Specialist coinsurance**	**10%**
■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$370**

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