**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.mech701-benefits.org or call 1-800-704-6270. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250** individual<br>**$500** 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. **Preventive care**, outpatient pre-admission tests, and certain diabetic supplies under the Plan's **prescription drug** benefit 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 **co-insurance** 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. **$500** per non-Emergency admission to **out-of-network providers**. There are no other specific **deductibles.** | 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?** | For major medical **network providers**:<br>**$2,500** individual**; $5,000** family;<br>For **prescription drug coverage**:<br>**$6,950** individual; **$13,900** family;<br>For **out-of-network providers**, an additional **$1,000** individual; **$2,000** 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, 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 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without a **referral**. |

All **copayment** and **co-insurance** 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, and 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% **co-insurance** | 30% **co-insurance** | None. |
| | **Specialist** visit | 20% **co-insurance** | 30% **co-insurance** | None. |
| | **Preventive care/ screening/ immunization** | No charge; **deductible** does not apply | Not covered | You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for. |
| **If you have a test** | **Diagnostic test** (x-ray, blood work) | 20% **co-insurance** | 30% **co-insurance** | Outpatient pre-admission tests covered at no cost with no **deductible**. Genetic tests that are not required by law are covered if deemed **medically necessary**. |
| | Imaging (CT/PET scans, MRIs) | 20% **co-insurance** (0% **co-insurance** and no **deductible** if you use a **provider** contracted with the **Plan**'s designated imaging provider network) | 30% **co-insurance** | Outpatient pre-admission tests covered at no cost with no **deductible**. If you use a provider contracted with the **Plan**'s designated imaging provider network (Absolute Solutions), then imaging services are covered at no cost to you. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.empirxhealth.com | | **Network Pharmacies - 30 You pay the lesser of the actual drug cost or:** | **Mail or Network Pharmacies - 90 You pay the lesser of the actual drug cost or:** | |
| | Generic drugs | $6 for up to a 30-day supply | $15 for a 90-day supply | Not Covered | None. |

All **copayment** and **co-insurance** 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, and Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (You will pay the least) | | Out-of-Network Provider (You will pay the most) | |
| | Preferred brand drugs | $25 for up to a 30-day supply | $65 for a 90-day supply | Not Covered | None. |
| | Non-preferred brand drugs | $40 for up to a 30-day supply | $100 for a 90-day supply | Not Covered | None. |
| | Specialty drugs | 100% **co-insurance**. If **co-insurance** assistance is unavailable for a drug, the **co-insurance** defaults to the tiered structure shown above. | | Not Covered | The Fund's contracted specialty drug case manager will work with drug manufacturers so that the cost to you does not exceed the tiered structure shown above. |
| **If you have outpatient surgery** | Facility fee | 10% **co-insurance** | | 30% **co-insurance** | **Out-of-network** ambulatory surgery centers not covered. |
| | Physician/surgeon fees | 10% **co-insurance** | | 30% **co-insurance** | None. |
| **If you need immediate medical attention** | **Emergency room services** | 20% **co-insurance** | | 20% **co-insurance** (30% if non-emergency) | None. |
| | **Emergency medical transportation** | 20% **co-insurance** | | 20% **co-insurance** | None. |
| | **Urgent care** | 20% **co-insurance** | | 30% **co-insurance** | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% **co-insurance** | | 30% **co-insurance** | **Preauthorization** is required. Coverage limited to single private room rate. Coverage at **out-of-network** Hospital Intensive Care limited to Full Reasonable and Customary Rate. **Out-of-network providers** subject to $500 **deductible** for non-emergency admission. |
| | Physician/surgeon fee | 10% **co-insurance** | | 30% **co-insurance** | None. |

 All **copayment** and **co-insurance** 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, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | 10% **co-insurance** | 30% **co-insurance** | None. |
| | Inpatient services | 10% **co-insurance** | 30% **co-insurance** | **Preauthorization** is required. Inpatient substance abuse services are covered if provided by a Hospital or approved Residential Treatment Facility. |
| **If you are pregnant** | Office visits | 20% **co-insurance** | 30% **co-insurance** | **Preventive care** services covered at no cost at PPO providers. Expenses for a dependent child's pregnancy not covered, except as required under applicable law. |
| | Childbirth/delivery professional services | 10% **co-insurance** | 30% **co-insurance** | |
| | Childbirth/delivery facility services | 10% **co-insurance** | 30% **co-insurance** | |
| **If you need help recovering or have other special health needs** | **Home health care** | 20% **co-insurance** | 30% **co-insurance** | Physician should contact MCM/Valenz Care for **preauthorization**. |
| | **Rehabilitation services** | 20% **co-insurance** | 30% **co-insurance** | 30 rehabilitative speech therapy visits/year per person; 20 rehabilitative physical therapy visits/year per person. Physician should contact MCM/Valenz Care for **preauthorization**. |
| | **Habilitation services** | 20% **co-insurance** | 30% **co-insurance** | Habilitative services to develop a function are limited to 30 visits/year per person for speech therapy or a combined 70 visits/year per person for speech and physical therapy. Speech therapy of an idiopathic developmental delay nature, educational or provided by school is not covered. |
| | **Skilled nursing care** | 20% **co-insurance** | 30% **co-insurance** | Physician should contact MCM/Valenz Care for **preauthorization**. |

All **copayment** and **co-insurance** 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, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | **Durable medical equipment** | 20% **co-insurance** | 30% **co-insurance** | Physician should contact MCM/Valenz Care for **preauthorization**. |
| | **Hospice service** | 20% **co-insurance** | 30% **co-insurance** | Coverage limited to Hospice Care program covered expenses. Physician should contact MCM/Valenz Care for **preauthorization**. |
| **If your child needs dental or eye care** | Children's eye exam | $10 **co-pay** | All costs over $35 | Coverage limited to one exam per calendar year. |
| | Children's glasses | $20 **co-pay** | All costs over $40 (single vision), $56 (lined bifocal), or $68 (lined trifocal) | Coverage limited to $175 every calendar year at **network providers** or $50 every year at **out-of-network providers**. |
| | Children's dental check-up | No charge after $25 **deductible** for routine services | Fees and costs above what is allowed and agreed as Reasonable and Customary | Basic, Major and Orthodontia services covered at 50% **co-insurance**; $2,000 calendar year maximum for dental benefits (except for preventive oral care for children under 19); $4,000 per person lifetime orthodontia maximum. |

**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.)**

- Cosmetic Surgery
- Genetic Testing (unless approved by the Trustees)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy coverage for dependent children
- Private-duty nursing
- Routine foot care (except for limited orthotics coverage)
- Speech therapy for an idiopathic developmental delay nature, educational, or provided by school

| |
|---|
| • Weight loss programs (except as required under the ACA preventive services mandate) |

| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** |
|---|
| • Acupuncture |
| • Bariatric Surgery (subject to certain conditions) |
| • Chiropractor care (up to 12 visits per person per calendar year; includes services for care of the back, neck, spine, and vertebrae) |
| • Dental care (Adult) |
| • Hearing aids (up to $2,500 per person every three years) |
| • Infertility treatment (up to $10,000 per person per lifetime) |
| • Routine eye care (Adult) (once per calendar year) |

**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. 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 1-800-704-6270.

*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 co-insurance) 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 | $250 |
| Specialist co-insurance | 20% |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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 | $250 |
| Copayments | $10 |
| Co-insurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,720** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist co-insurance | 20% |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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 | $250 |
| Copayments | $100 |
| Co-insurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$770** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist co-insurance | 20% |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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 | $250 |
| Copayments | $10 |
| Co-insurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$760** |

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