



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.csjunion.org/healthandwelfare](http://www.csjunion.org/healthandwelfare) or call 1-312-738-0822. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> and <a href="#">out-of-area providers</a> : <b>\$1,000</b> per person/ <b>\$3,000</b> per family per calendar year; for <a href="#">out-of-network providers</a> : Not applicable.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan 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, in-network <a href="#">preventive care</a> and wellness 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="#">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="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> and <a href="#">out-of-area providers</a> : <b>\$3,800</b> per person/ <b>\$11,400</b> per family per calendar year; for <a href="#">out-of-network providers</a> : Not applicable.	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 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>	Penalties for failure to obtain pre-authorization, <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. For a list of <a href="#">preferred providers</a> , see <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-888-810-BLUE (2583) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You 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 charge</a> 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copayment</u> /office visit	Not Covered	-----None-----
	<u>Specialist</u> visit	\$50 <u>copayment</u> /office visit	Not Covered	Chiropractic services subject to <u>20% coinsurance</u> and limited to \$500 per year.
	<u>Preventive care/screening/immunization</u>	No Charge ( <u>Deductible</u> does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. See a list of covered <u>preventive services</u> at: <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	-----None-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.rxsolutions.com">prescription drug coverage</a> is available at <a href="http://www.rxsolutions.com">www.rxsolutions.com</a>	<b>Retail (30-day supply) or Mail (90-day supply)</b>			
	Generic drugs	10% <u>coinsurance</u> , with a \$200 maximum per prescription	Not Covered	
	Brand drugs	35% <u>coinsurance</u> , with a \$200 maximum per prescription	Not Covered	\$5,400 per person/\$7,000 per family in-network <u>out-of-pocket limit</u> per calendar year.
	Brand drugs when Generic is available	35% <u>coinsurance</u> , with a \$200 maximum per prescription, plus 100% of the difference in cost of the generic and brand name medication	Not Covered	Maintenance drugs must be filled through the OptumRx Mail Service Pharmacy, which covers up to a 90-day supply.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , with a \$250 maximum per prescription	Not Covered	

\* For more information about limitations and exceptions, see the plan document at [www.csjunion.org](http://www.csjunion.org) or call 1-312-738-0822.

<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>		Certain types of surgeries must be performed on an outpatient basis. Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <u>coinsurance</u> after \$400 <u>copayment</u> per emergency room visit		<u>Copayment</u> waived if admitted to Hospital within 48 hours of treatment.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	Not Covered except air ambulances covered at 20% coinsurance	Coverage limited to first trip to and/or from Hospital for any one sickness or for all injuries resulting from any one accident.
	<a href="#">Urgent care</a>	\$25 <u>copayment</u>	Not Covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>		Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees			
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>		Pre-certification required for inpatient and outpatient services; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . Pre-certification requirement does not apply to office visits.
	Inpatient services			
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>		Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> . <u>Preventive services</u> are covered at no cost.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .  Limited to 60 visits per calendar year. If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> and are limited to 40 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .

	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .  If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	<a href="#">Hospice services</a>	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .  If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam		Not Covered	Vision screening for children is covered as a <u>preventive service</u> with no charge.
	Children's glasses			
	Children's dental check-up			

**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
- Cosmetic surgery (unless performed to correct congenital defect, defects incurred through traumatic injury, or malfunctioning organs)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the United States
- Private duty nursing
- Routine eye care (Adult)

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

- Bariatric surgery
- Chiropractic care (\$500 calendar year maximum)
- Infertility treatment (\$5,000 lifetime maximum; Employee and eligible Spouse only)
- Routine foot care
- Weight loss program (if 100% over medically desired weight; threat to life; and medical history of unsuccessful attempt to lose weight by other methods)

\* For more information about limitations and exceptions, see the plan document at [www.csjunion.org](http://www.csjunion.org) or call 1-312-738-0822.

**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 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 1-312-738-0822. 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](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at 1-877-527-9431 or <http://insurance.illinois.gov/>.

**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 1-312-738-0822.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-312-738-0822 uff.

*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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$0
<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>\$3,360</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.