



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, call 1-847-827-1029. 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](http://www.dol.gov/ebsa/healthreform) or call 1-847-827-1029 to request a copy.

| Important Questions  | Answers   | Why This Matters:  |
|--|---|--|
| <b>What is the overall deductible?</b>                             | \$150 per individual/\$450 per family   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive services</u> , second and third opinions, dental services, vision services, imaging provided <u>in-network</u> , <u>prescription drugs</u> , and private-duty nursing are covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>   |
| <b>Are there other deductibles for specific services?</b>          | Yes. \$10 per individual/\$30 per family for dental. There are other specific <u>deductibles</u> .  | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | <b>Medical:</b> \$1,000 per individual/\$1,500 per family<br><b>Prescription Drugs:</b> \$8,200 per individual/\$16,900 per family  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain precertification for services, and health care this <u>plan</u> does not cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> (select "PPO Plus") or call 1-800-810-2583 for a list of <u>network providers</u> ; for dental <u>providers</u> see <a href="http://www.dnoa.com">www.dnoa.com</a> or call 1-866-522-6758; for vision <u>providers</u> see <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a> or call 1-866-723-0513; for hearing call Amplifon (formerly HearPO) at 1-888-432-7464; for MRI/CT/PET Scans call Absolute Solutions at 1-800-321-5040 or <a href="http://www.absolutedx.com">www.absolutedx.com</a> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No.     | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)            |   |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                       | 30% <u>coinsurance</u> after additional \$5 <u>deductible</u> | None  |
|   | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                       | 30% <u>coinsurance</u> after additional \$5 <u>deductible</u> | None  |
|   | <u>Preventive care/screening/immunization</u>    | No charge. <u>Deductible</u> does not apply. | No charge. <u>Deductible</u> does not apply.                  | Adult physical limited to one every 12 months. You may have to pay for services that the <u>plan</u> does not consider preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>  | None  |
|   | Imaging (CT/PET scans, MRIs)                     | No charge. <u>Deductible</u> does not apply. | 20% <u>coinsurance</u>  | None  |

| Common Medical Event   | Services You May Need     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|---------------------------|---|--|---|
|  |                           | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a>.</p> | Generic drugs             | 20% <u>coinsurance</u> retail; \$15 <u>copay</u> per fill mail order & Maintenance Care. <u>Deductible</u> does not apply.  | Not covered  | <p>Covers up to a 30-day supply at retail; up to a 90-day supply if using mail-order or Maintenance Care at CVS; two-fill limit of maintenance drugs at retail. This includes oral contraceptives.</p> <p>Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u>.</p> <p>No charge for FDA-approved generic preventive drugs, including contraceptives (or brand name contraceptives if a generic is medically inappropriate).</p> |
|  | Preferred brand drugs     | 20% <u>coinsurance</u> retail; \$40 <u>copay</u> per fill mail order & Maintenance Care if no generic available, \$60 <u>copay</u> per fill if generic available. <u>Deductible</u> does not apply. | Not covered  |   |
|  | Non-preferred brand drugs | 20% <u>coinsurance</u> retail; \$40 <u>copay</u> per fill mail order & Maintenance Care if no generic available, \$60 <u>copay</u> per fill if generic available. <u>Deductible</u> does not apply. | Not covered  |   |
|  | <u>Specialty drugs</u>    | 20% <u>coinsurance</u> retail; \$40 <u>copay</u> per fill mail order & Maintenance Care if no generic available, \$60 <u>copay</u> per fill if generic available. <u>Deductible</u> does not apply. | Not covered  |   |

| Common Medical Event   | Services You May Need                          | What You Will Pay                                   |  | Limitations, Exceptions, & Other Important Information  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)        | Out-of-Network Provider<br>(You will pay the most)   |   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                              | 30% <u>coinsurance</u> in outpatient hospital setting; not covered in outpatient surgical facility | Precertification is required for surgeries of \$5,000 or more to avoid \$200 noncompliance penalty.<br><br>For precertification, call Valenz at 1-800-367-9938. |
|  | Physician/surgeon fees                         | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u> in outpatient hospital setting; not covered in outpatient surgical facility |   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>   | None  |
|  | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>   | None  |
|  | <u>Urgent care</u>                             | 20% <u>coinsurance</u> after \$50 <u>deductible</u> | 20% <u>coinsurance</u> after \$50 <u>deductible</u>  | No charge for first aid within 72 hours of injury up to \$300 after <u>deductible</u> .   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                              | 30% <u>coinsurance</u> after additional \$250 <u>deductible</u>                                    | Precertification is required to avoid \$200 noncompliance penalty.<br><br>For precertification, call Valenz at 1-800-367-9938.                                  |
|  | Physician/surgeon fees                         | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | 20% <u>coinsurance</u>                              | 30% <u>coinsurance</u> ; additional \$5 <u>deductible</u> also applies to office visits            | None  |
|  | Inpatient services                             | 20% <u>coinsurance</u>                              | 30% <u>coinsurance</u> after additional \$250 <u>deductible</u>                                    | Precertification is required to avoid \$200 noncompliance penalty.<br><br>For precertification, call ComPsych at 1-877-327-7798.                                |

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you are pregnant  | Office visits                             | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prenatal care (other than ACA-required <u>preventive screenings</u> ) is not covered for dependent children. Delivery charges are not covered for dependent children. |
|  | Childbirth/delivery professional services | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             |  |
|  | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                             |  |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | 90 shifts for private-duty nursing per calendar year.  |
|  | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | Precertification required for physical therapy if treatment exceeds 26 visits per calendar year.<br>Occupational therapy limited to 26 visits per calendar year.<br>Speech therapy limited to 26 visits per calendar year.<br>Custodial care is not covered.   |
|  | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | Custodial care is not covered.   |
|  | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                             | Maximum of 90 days per individual per calendar year.   |
|  | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | Precertification is required for equipment of \$5,000 or more to avoid non-payment of benefits.<br>For precertification, call Valenz at 1-800-367-9938.  |
|  | <u>Hospice services</u>                   | 20% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                             | Precertification is required to avoid nonpayment of benefits.<br>For precertification, call Valenz at 1-800-367-9938.  |

| Common Medical Event                   | Services You May Need      | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------|--|---|--|
|  |                            | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |  |
| If your child needs dental or eye care | Children's eye exam        | No charge. <u>Deductible</u> does not apply.   | No charge up to \$30. <u>Deductible</u> does not apply.   | Limited to one exam per calendar year. Vision benefits separately administered by EyeMed.  |
|  | Children's glasses         | Frames: no charge up to \$100; you pay the remaining amount at a 20% discount on the retail price<br><br>Single vision lenses: No charge after \$5 <u>copay</u> per set. <u>Deductible</u> does not apply. | Frames: No charge up to \$30<br>Lenses: No charge up to \$50. <u>Deductible</u> does not apply. | Limited to one pair of frames and lenses per calendar year. Bifocals and trifocals subject to a higher <u>in-network copay</u> than single vision lenses. Vision benefits separately administered by EyeMed. |
|  | Children's dental check-up | No charge. <u>Deductibles</u> do not apply.  | No charge. <u>Deductibles</u> do not apply.   | Limited to one check-up every 6 months. Separately administered by Dental Network of America.  |

## 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
- Gene and Cellular Therapy Treatments and Gene and Cellular Therapy Prescription Drugs
- Long-term care
- Non-emergency (and emergency) care when traveling outside the U.S.

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

- Bariatric surgery (Adults Only; once per lifetime if prerequisites are met)
- Chiropractic care (\$2,000 per individual per calendar year)
- Dental care (Adults age 19 and older) (\$1,000 per individual per calendar year. Separately administered by Dental Network of America.)
- Hearing aids (No charge for first \$500; thereafter, 20% coinsurance in-network and 30% coinsurance out-of-network every 3 calendar years)
- Infertility treatment (\$30,000 per individual per lifetime, Employee and spouse only)
- Private-duty nursing (90 shifts per individual per calendar year)
- Routine eye care (Adult) (exam and materials limits apply. Separately administered by EyeMed.)
- Routine foot care
- Weight loss programs (Adult only) (one non-preventive treatment course per lifetime for obesity if prerequisites are met and as required by health reform law)

**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 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: Ms. Sherri Dunne, Fund Administrator, Roofers' Unions Welfare Trust Fund, 2021 Swift Drive, Suite B, Oak Brook, Illinois 60523, Telephone: 1-847-827-1029. 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).

### 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 1-847-827-1029.

*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 <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Specialist coinsurance</u>               | 20%   |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%   |
| ■ <u>Other coinsurance</u>                    | 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$150          |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$850          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,060</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |       |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Specialist coinsurance</u>               | 20%   |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%   |
| ■ <u>Other coinsurance</u>                    | 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$150          |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$230          |
| <b>The total Joe would pay is</b> | <b>\$1,380</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |       |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Specialist coinsurance</u>               | 20%   |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%   |
| ■ <u>Other coinsurance</u>                    | 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$150        |
| <u>Copayments</u>                 | \$0          |
| <u>Coinsurance</u>                | \$530        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$680</b> |

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