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.central-laborers.com or call 1-800-252-6571. 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 1-800-252-6571 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$125** per person/**$375** per family; Out-of-network: **$1,900** per person/**$5,700** per 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?	Prescription drugs, physician office visits, adult annual physical exam, well-child benefit network provider, vision services and hearing services 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.
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?	Network: **$9,500** per person/ **$28,500** per family; Out-of-network: no limit	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?	Prescription drugs, premiums, balance billing charges, copayments 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.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 **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	$25 copay per visit. Deductible does not apply.	50% coinsurance	None
	Specialist visit	$25 copay per visit. Deductible does not apply. 20% coinsurance after deductible for chiropractic/spinal manipulation.	50% coinsurance	Plan pays up to $100 per consultation for 2nd & 3rd network surgical opinions. Chiropractic/spinal manipulation limited to $1,000 and 60 treatments per person per calendar year for related therapy. TMJ limited to $500 per person per calendar year. Network podiatry: $25 copay per visit for physician services and 20% coinsurance applies to other services (orthotics limited to $500 per person per calendar year).
	Preventive care/screening/ immunization	No charge up to $400 for adults and $200 for children and deductible does not apply, then 20% coinsurance.	No charge up to $400 for adults and $200 for children and deductible does not apply, then 20% coinsurance.	Specific limits apply to immunizations. Out-of-network well child exams only covered if provided through the Public Health Department.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-866-818-6911.	Generic drugs	$15 copay per 30-day supply (retail); $25 copay per 90-day supply (retail and mail order). Deductible does not apply.	Not covered	Supply: 30-day or 90-day for maintenance medications retail (at CVS); 90-day mail-order. 90-day copay is the same for retail or mail order supply. Cost sharing does not count toward out-of-pocket limit.
	Formulary brand name drugs with no generic/formulary available	$50 copay per 30-day supply (retail); $100 copay per 90-day supply (retail and mail order). Deductible does not apply.		

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)	
	Non-formulary brand name drugs with generic/formulary available	$125 copay per 30-day supply plus difference between formulary brand and non-formulary brand drug (retail); $250 copay per 90-day plus difference between formulary brand and non-formulary brand drug (retail and mail order). Deductible does not apply.	Not covered	Supply: 30-day or 90-day for maintenance medications retail (at CVS); 90-day mail-order. 90-day copay is the same for retail or mail order supply. Cost sharing does not count toward out-of-pocket limit.
	Specialty drugs	20% coinsurance up to $100 per fill	Not covered	Supply: 30-day only through CVS Specialty Pharmacy by mail order. Cost sharing does not count toward out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% 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)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$155 copay for professional services; 20% coinsurance for other services	$155 copay for professional services; 20% coinsurance for other services	Cost sharing requirements for out-of-network emergency services are no greater than the cost sharing requirements that would apply if the services were provided by a network provider.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance for network and out-of-network air ambulance services
	Urgent care	$40 copay for professional services; 20% coinsurance other services	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Limited to semi-private room rate.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay for office visits; deductible does not apply. 20% coinsurance for other services.	50% coinsurance for mental health treatment. 50% coinsurance for substance abuse services.	None
	Inpatient services	20% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	$25 copay per visit. Deductible does not apply.	50% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance		
	Childbirth/delivery facility services	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)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Up to 40 visits per person per calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Up to 60 outpatient visits per person per calendar year. Inpatient services are not covered. $25,000 prosthetic device maximum per person per calendar year. Speech therapy only if required for head injury/stroke or paradoxical vocal cord motion (up to restoration of normal functions present before injury or stroke). Custodial Care is not covered.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Skilled nursing care	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge and deductible does not apply up to $200; after $200, 20% coinsurance	No charge and deductible does not apply up to $200; after $200, 20% coinsurance	You may opt-out of vision benefits.
	Children's glasses	No charge; deductible does not apply	No charge; deductible does not apply	$300 per purchase maximum on eye glasses (lenses and frames) and/or contact lenses, subject to medical necessity. Prescription required for purchase. Replacement of lost or stolen items not covered. You may opt-out of vision benefits.
	Children's dental check-up	20% coinsurance	20% coinsurance	$2,500 maximum per person age 19 and older per calendar year. One dental exam and cleaning per person every 6 months. You may opt-out of dental benefits.

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 (except for reconstructive surgery following mastectomy & other exceptions)
- Habilitation services
- Infertility treatment
- Long-term care
- Skilled nursing care
- Weight loss programs (unless physician supervised if certain conditions are met)

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

- Acupuncture (within chiropractic $1,000 annual limit)
- Bariatric surgery (for treatment of obesity if certain conditions are met)
- Chiropractic care ($1,000 annual limit)
- Dental care (Adult) ($2,500 per person annual limit)
- Hearing aids (Up to $750 per person once every 60 consecutive month period)
- Non-emergency care when traveling outside the U.S. (at out-of-network level, exchange rate as of date-of-service, documentation required)
- Private-duty nursing (if medically necessary)
- Routine eye care (Adult) (up to $300 per person annual limit)
- Routine foot care (orthotics maximum of $500 per person 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: the U.S. 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 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: Fund Administrator, Central Laborers' Welfare Fund, 201 North Main Street, P.O. Box 1267, Jacksonville, IL 62651-1267, Telephone 1-217-243-8521 or 1-800-252-6571, or www.central-laborers.com. 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.

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 1-800-252-6571.

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 network prenatal care and a hospital delivery)

- **The plan's overall deductible** **$125**
- **Specialist copay** **$25**
- **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	$125
Copayments	$60
Coinsurance	$2,490
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,695**

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

- **The plan's overall deductible** **$125**
- **Specialist copay** **$25**
- **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	$125
Copayments	$1,480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$270
The total Joe would pay is	**$1,875**

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

- **The plan's overall deductible** **$125**
- **Specialist copay** **$25**
- **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	$125
Copayments	$500
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$955**

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