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.ibt731funds.org or call 1(630)887-4150. 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(630) 887-4150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual deductible: $400.00 Family deductible: $1,200.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, As per the Affordable Care Act are covered before you meet your deductible. Diagnostic services scheduled through Absolute Solutions, Sleep Studies arranged through Valenz.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical is $3,400.00 per person / $7,200.00 per family Rx is $5,700.00 per person / $11,000.00 per family (These totals include deductible)	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. If you have other family members in this plan, they have to meet their 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?	Payroll deductions towards coverage, infertility, chiropractic care, balance billed items, amounts over maximum benefit coverage, amounts over allowed amounts, failure to obtain precertification.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. You can visit www.bcbsil.com or call 1(800) 810-2583 to locate an in-network provider.	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 permission from this plan.

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	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary. Chiropractic care / Acupuncture limited to 25 visits per year; TMJ limited to 20 visits per year.
	Specialist visit	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary.
	Preventive care/screening/ immunization	Member/Spouse = $0.00 Children = $0.00 Deductible Waived	Member/Spouse = 30% Children = $0.00 Deductible Waived	Follow guidelines as established by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary
	Imaging (CT/PET scans, MRIs)	Absolute Solutions or Future Diagnostics = $0.00 PPO = 20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary. No coinsurance or deductible for Absolute Solutions network providers.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ibt731funds.org OR www.empirxhealth.com	Generic drugs	34-day Retail copayment = $10.00 100-day Retail/Mail Order copayment = $25.00	Reimbursement based on contracted rate, minus coinsurance amount	Covers 34-day supply AND 100-day supply (Maintenance Drugs)
	Preferred brand drugs	34-day Retail copayment = $15.00 100-day Retail/Mail Order copayment = $50.00	Reimbursement based on contracted rate, minus coinsurance amount	Covers 34-day supply AND 100-day supply (Maintenance Drugs)
	Non-preferred brand drugs	34-day Retail copayment = $40.00 100-day Retail/Mail Order copayment = $125.00	Reimbursement based on contracted rate, minus coinsurance amount	Covers 34-day supply AND 100-day supply (Maintenance Drugs)
	Specialty drugs	100% copayment assistance. If copayment assistance is unavailable for a drug, its copayment defaults to the tiered structure shown above.	Not covered	Covers 30-day supply only 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.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Ambulatory Surgical Center: 100%	Out-of-network ambulatory surgical centers are not covered under this plan. Precertification is required or $250.00 penalty.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Precertification is required or $250.00 penalty.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Must be medically necessary.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Must be medically necessary.
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	Must be medically necessary.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary. Precertification is required or $250.00 penalty.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral Health Inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary. Precertification is required for Inpatient, or $250.00 penalty. Marriage counseling and family counseling are excluded.
	Mental/Behavioral Health Outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must be medically necessary. Marriage counseling and family counseling are excluded.
	Substance use disorder Inpatient services	20% coinsurance after deductible	30% coinsurance after deductible.	Must be medically necessary. Precertification is required for Inpatient, or $250.00 penalty.
	Substance use disorder Outpatient services	20% coinsurance after deductible	30% coinsurance after deductible.	Must be medically necessary.
If you are pregnant	Office visits	$0.00 if global fee or 20% coinsurance after deductible.	30% coinsurance after deductible	

* For more information about limitations and exceptions, see the Summary Plan Description at www.ibt731funds.org.

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 are pregnant (Continued)	Childbirth/delivery professional services	$0.00 if global fee after deductible, or 20% coinsurance after deductible.	30% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible.	30% coinsurance after deductible	Precertification is required upon delivery or $250.00 penalty.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible.	30% coinsurance after deductible	Must be medically necessary. Precertification is required or $250.00 penalty.
	Rehabilitation services	20% coinsurance after deductible.	30% coinsurance after deductible	Must be medically necessary. Precertification is required for speech therapy or $250.00 penalty.
	Habilitation services	20% coinsurance after deductible.	30% coinsurance after deductible	Must be medically necessary.
	Skilled nursing care	20% coinsurance after deductible.	30% coinsurance after deductible	Must be medically necessary. Precertification is required or $250.00 penalty.
	Durable medical equipment	20% coinsurance after deductible.	30% coinsurance after deductible	Must be medically necessary. Precertification is required for all DME over $500.00 and for all c-pap machines and supplies, regardless of the cost or $250.00 penalty.
	Hospice services	$0.00	$0.00	Maximum days covered per lifetime: Home hospice care = 62 days OR Inpatient hospice care = 30 days
If your child needs dental or eye care	Children's eye exam	$0.00	$0.00 up to $50.00 per vision exam	Davis Vision Unlimited routine vision exams for children through age 19 only (excludes contact lens fitting and evaluation fees).
	Children's glasses	Frames: $0.00 up to $225.00 Amount over frame allowance = 80% Lenses: $0.00 Lens Options = discounted contracted rate	$0.00 up to $250.00 allowance towards all frames, lenses and contact lenses.	Davis Vision Glasses or contact lenses once every other year calendar year. Or once per year, if there is a .50 diopter change (This frequency is for children through age 19 only).

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 your child needs dental or eye care (Continued)		***or*** $0.00 for contact lenses up to $300.00.		
	Children's dental check-up	(Delta Dental PPO) Preventative / Diagnostic = $0.00	(Delta Dental Premier and Non-Contracted) 20%	$25 calendar year family deductible waived for preventative / diagnostic care.

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.)

- Abortions
- Amounts over the plan's allowable reimbursement
- Cosmetic surgery
- Health Club Membership
- Long term care
- Over-the-counter medications
- Services covered by Workers Compensation
- Services that are not medically necessary
- Transportation

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

- Hearing Aids
- Vision Coverage for Adults
- Dental ($3,000.00 per year max / Orthodontic Coverage for Adults (4,000.00 lifetime max)

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: U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov. 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: Teamsters Local 731 Fund Office at (630) 887-4150 or www.ibt731funds.org or U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Employee Resource Systems at (800) 292-2780 or www.ers-eap.com (username: ibt731 / Password: teamsters).

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.

* For more information about limitations and exceptions, see the Summary Plan Description at www.ibt731funds.org.

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 (630) 887-4150

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 plan's overall deductible	**$400.00**
Specialist coinsurance	**20%**
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	**$12,700.00**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400.00
Copayments	$0.00
Coinsurance	$2,460.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$2,860.00**

*Professional global delivery fee covered at 100%

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

The plan's overall deductible	**$400.00**
Specialist coinsurance	**20%**
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	**$5,600.00**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400.00
Copayments	$0.00
Coinsurance	$1,040.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$1,440.00**

Plan pays diabetic services and supplies at 100% for member and spouse if they participate in the Wellness Program each year.

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

The plan's overall deductible	**$400.00**
Specialist coinsurance	**20%**
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	**$2,800.00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400.00
Copayments	$0.00
Coinsurance	$480.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$880.00**

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