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 1-866-828-0900 or visit us at www.fvlab.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-866-828-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** person / **$400** family Carry forward of October, November and/or December expenses satisfying the deductible to the next calendar year	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. Certain preventive care and prescription drugs 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?	Yes. Dental: **$50** person. Doesn't apply to preventive dental care. 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?	Medical: **$1,500** person, plus $150 deductible	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Balance billing charges, health care this plan doesn't cover and prescription drug copayments	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	10% coinsurance	20% coinsurance	For accidental injury, Plan pays 100% of covered expenses for office visits, physician services, and hospital charges incurred within 48 hours of the injury, up to $750 per person per calendar year (deductible waived).
	Specialist visit	10% coinsurance	20% coinsurance	Chiropractic care and acupuncture is covered for individuals over age five for treatment of the back, neck, spine, and vertebra, for conditions due to subluxation, strains, sprains, and nerve root problems. The care must be provided by a physician.
	Preventive care/screening/ immunization	No charge (deductible waived)	No charge (deductible waived)	Provider must be a physician. Employee and spouse routine exams and immunizations are covered. Immunizations at a pharmacy or retail clinic are covered. Dependent children routine exams and immunizations are not covered unless mandated by the Board of Education for school or school related athletic participation.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	None

*For more information about limitations and exceptions, call 1-866-828-0900. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail** - $8 copayment/prescription; **Mail Order** - $15 copayment/prescription	**Retail** – 50% coinsurance after $8 copayment/ prescription; if no in-network pharmacy available within zip code, 20% coinsurance after $8 copayment/ prescription	Covers up to 30-day supply (retail); 90-day supply (mail order). Mail order is required for maintenance medications after two pharmacy fills. Certain prescriptions are not covered, including prescriptions that are not on the pharmacy network formulary list. Certain drugs require prior authorization. If you don't get preauthorization, benefits could be reduced where plan pays nothing. Clinical management programs apply to certain prescription drugs, including specialty medications. Specialty drugs must be dispensed by the CVS/Caremark specialty pharmacy.
	Preferred brand drugs	**Retail** - $15 copayment/prescription; **Mail Order** - $30 copayment/prescription; And, if generic is available copayment is $15 or $30 plus the cost differential between the brand name and generic drug.	**Retail** – 50% coinsurance after $15 copayment/ prescription; if no in-network pharmacy available within zip code, 20% coinsurance after $15 copayment/ prescription	
	Non-preferred brand drugs	Same as preferred	Same as preferred	
	Specialty drugs	Same as preferred	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	20% coinsurance	If accidental injury care received within 48 hours of the injury, deductible does not apply and coinsurance does not apply to the first $750 of charges.
	Emergency medical transportation	10% coinsurance	20% coinsurance	Air transportation is covered only if due to inaccessibility by ground transport or ground transport would be detrimental to the patient's health status.
	Urgent care	10% coinsurance	20% coinsurance	None

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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 a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Private rooms are only covered if it is determined to be medically necessary; weekend admission (Friday or Saturday) is covered only if treatment or surgery is provided within 24 hours of hospital admission.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	Inpatient facility must meet Plan requirements. Mental/Behavioral health covered if provided by a licensed psychiatrist, Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), a clinical psychologist, licensed clinical professional counselor, or licensed social worker.
	Inpatient services	10% coinsurance	20% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	Physical and occupational therapy is covered for a continuous course of treatment for up to 26 weeks (short-term) for a specific condition when performed by a registered physical therapist and licensed occupational therapist. Physical therapy is not covered if performed by a chiropractor. Chiropractic care is not covered if received at the same time as physical therapy. Extension of benefits can be approved in 4 week increments up to 52 weeks if due to an accidental injury resulting in hospitalization. Speech therapy is covered if it's to restore speech as a result of an accidental injury or illness or to restore speech in individuals who are unable to speak as a result of a hearing

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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)	
				disorder. Speech therapy is only covered if performed by a licensed speech therapist.
	Habilitation services	10% coinsurance	20% coinsurance	Physical and occupational therapy is covered for dependents with congenital disability.
	Skilled nursing care	10% coinsurance	20% coinsurance	Must be provided by a licensed registered or practical nurse and prescribed by a physician.
	Durable medical equipment	10% coinsurance. Covers the rental of durable medical equipment not to exceed a reasonable purchase price	20% coinsurance. Covers the rental of durable medical equipment not to exceed a reasonable purchase price.	Purchase of medically necessary equipment and cost of maintenance agreements are covered only when the plan determines that it is cost effective.
	Hospice services	10% coinsurance	20% coinsurance	Coverage limited to an individual who is diagnosed as terminally ill with 6 months or less to live by a certified physician.
If your child needs dental or eye care	Children's eye exam	No charge (deductible waived)	No charge (deductible waived)	None
	Children's glasses	No charge	No charge	$300 calendar year limit.
	Children's dental check-up	Preventive Care - No charge (deductible waived) General Care – 15% coinsurance (dental deductible applies)	Preventive Care - No charge (deductible waived) General Care – 15% coinsurance (dental deductible applies)	Dental x-rays fall under General Care. Annual limit for children: up to age 18 – no annual limit age 18 and over – $1,500 limit

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 (limited exceptions)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (authorization required)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment (excluding children)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (transplant care)
- Routine eye care (Adult)

*For more information about limitations and exceptions, call 1-866-828-0900. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

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 1-866-444-3272 or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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, you can contact: the Fund Administrative Office at 1-866-828-0900 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

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.

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 1-866-828-0900.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

*For more information about limitations and exceptions, call 1-866-828-0900. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

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	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$30
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,490**

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

The plan's overall deductible	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other (Rx) copayments	$8/$15/Rx

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$440
Coinsurance	$280
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$930**

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

The plan's overall deductible	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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