
 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 1-866-692-0860 or visit www.ncilhwf.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 www.dol.gov/ebsa/healthreform or call 1-866-692-0860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-network</u> : \$750 person/\$1,500 family; <u>Out-of-network</u> : \$1,500 person/\$4,500 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Outpatient surgical procedures, second surgical opinion, in-network <u>preventive care</u> and <u>prescription drugs</u> , vision, hearing benefits, and dental are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you have not 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 person/\$100 family for dental. There are no 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> Medical: \$2,500 person/\$7,500 family; <u>In-network</u> Prescription Drugs: \$4,100 person/ \$5,700 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of <u>network providers</u> .	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</u> charge 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.
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 (You will pay the least)	Out-of-Network Provider (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>copay</u> /visit	50% <u>coinsurance</u>	-- None --
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	-- None --
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that are not 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>	50% <u>coinsurance</u>	-- None --
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.savrx.com .	Generic drugs	10% <u>coinsurance</u> , minimum \$10 <u>copay</u> /fill maximum \$20 <u>copay</u> /fill retail; 10% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$40 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the <u>copayment</u> . No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred Brand drugs	20% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$50 <u>copay</u> /fill retail; 20% <u>coinsurance</u> , minimum \$50 <u>copay</u> /fill maximum \$100 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.		
	Non-Preferred drugs	30% <u>coinsurance</u> , minimum \$35 <u>copay</u> /fill maximum \$125 <u>copay</u> /fill retail; 30% <u>coinsurance</u> , minimum \$100 <u>copay</u> /fill maximum \$250 <u>copay</u> /fill mail order. <u>Deductible</u> 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)	
	Specialty Drugs	20% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$50 <u>copay</u> /fill retail; 20% <u>coinsurance</u> , minimum \$50 <u>copay</u> /fill maximum \$100 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	<u>Preauthorization</u> is required, call 800-367-9938.
	Physician/surgeon fees	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Failure to preauthorize will result in \$250 penalty.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	-- None --
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate. This service is only available when emergency treatment is not available locally. Your physician must order the treatment and travel will only be covered to the nearest hospital providing the necessary medical care or treatment.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> services, call 800-367-9938.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Failure to preauthorize <u>out-of-network</u> services will result in \$250 penalty. Charges limited to semi-private room rates.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit for office visits; 20% <u>coinsurance</u> for day treatment and partial hospitalization. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	-- None --
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Out-of-network</u> Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency.</p> <p><u>Preauthorization</u> is required for <u>out-of-network</u> services, call 800-367-9938.</p> <p>Failure to preauthorize <u>out-of-network</u> services will result in \$250 penalty.</p> <p>Charges limited to semi-private room rates.</p>
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Cost sharing does not apply for preventive <u>screenings</u>.</p> <p>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Up to 40 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u>).
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Up to 60 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u> for medical and mental health conditions).

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)	
				<p><u>Preauthorization</u> may be required for certain services to avoid a \$250 penalty.</p> <p>Call 800-367-9938 to confirm if <u>preauthorization</u> is required. Failure to preauthorize will result in \$250 penalty.</p> <p><u>Out-of-network</u> Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency.</p> <p><u>Out-of-network</u> inpatient services are not covered, unless medical emergency.</p>
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Up to 60 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u> for medical and mental health conditions).</p> <p><u>Preauthorization</u> is required, call 800-367-9938.</p> <p>Failure to preauthorize will result in \$250 penalty.</p> <p><u>Out-of-network</u> inpatient services are not covered, unless medical emergency.</p>
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Maximum of 60 inpatient days per year.</p> <p>Maximum of 60 outpatient visits per year (combined maximum for <u>in-network</u> and <u>out-of-network</u>).</p>

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)	
				<u>Out-of-network</u> inpatient services are not covered, unless medical emergency.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covered if terminally ill. <u>Preauthorization</u> is required for <u>inpatient</u> services, call 800-367-9938. Failure to preauthorize <u>inpatient</u> services will result in \$250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	\$250 annual maximum; administered separately by Professional Benefit Administrators, Inc. <u>Deductible</u> does not apply.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge for children under 19, <u>deductible</u> does not apply; No charge after \$50 <u>deductible</u> for children 19 and over.	20% <u>coinsurance</u> after \$50 <u>deductible</u> ; <u>Deductible</u> does not apply for children under 19.	Coverage is limited to 2 exams/year. Administered separately by Delta Dental of Illinois.

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except as required by the ACA)

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

- Acupuncture (Covered under spinal manipulation benefit and smoking cessation benefit if prescribed by a physician)
- Bariatric surgery (Based on meeting criteria for life-threatening obesity)
- Chiropractic care (Up to 60 treatments or \$1,000 per year)
- Dental care (Adult) (Up to \$1,500 per year under separately administered plan)
- Hearing aids (Up to \$5,000 per lifetime; limit does not apply to exams)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) (Up to \$250 for all vision benefits combined under separately administered plan)
- Routine foot care (Up to \$500 per year for orthotics)

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. 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: the Fund Office at 1-866-692-0860 or at www.ncilhwhf.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.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington Street, 4th Floor, Springfield, Illinois 62767, 1-866-445-5364, <http://www.insurance.illinois.gov>, DOL.Director@illinois.gov.

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 1-866-692-0860.

-----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 \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$1,750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

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

- The plan's overall deductible \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$70
Copayments	\$260
Coinsurance	\$1,360
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$1,760

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

- The plan's overall deductible \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$390
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,160

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.

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Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>In-network</u> : \$750 person/\$1,500 family; <u>Out-of-network</u> : \$1,500 person/\$4,500 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Outpatient surgical procedures, second surgical opinion, in-network <u>preventive care</u> and <u>prescription drugs</u> , vision, hearing benefits, and dental are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you have not 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 person/\$100 family for dental. There are no 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>In-network</u> Medical: \$2,500 person/\$7,500 family; <u>In-network</u> Prescription Drugs: \$4,100 person/ \$5,700 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of <u>network providers</u> .	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</u> charge 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.
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 (You will pay the least)	Out-of-Network Provider (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>copay</u> /visit	50% <u>coinsurance</u>	-- None --
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	-- None --
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that are not 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>	50% <u>coinsurance</u>	-- None --
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.savrx.com .	Generic drugs	10% <u>coinsurance</u> , minimum \$10 <u>copay</u> /fill maximum \$20 <u>copay</u> /fill retail; 10% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$40 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the <u>copayment</u> . No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred Brand drugs	20% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$50 <u>copay</u> /fill retail; 20% <u>coinsurance</u> , minimum \$50 <u>copay</u> /fill maximum \$100 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.		
	Non-Preferred drugs	30% <u>coinsurance</u> , minimum \$35 <u>copay</u> /fill maximum \$125 <u>copay</u> /fill retail; 30% <u>coinsurance</u> , minimum \$100 <u>copay</u> /fill maximum \$250 <u>copay</u> /fill mail order. <u>Deductible</u> 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)	
	Specialty Drugs	20% <u>coinsurance</u> , minimum \$20 <u>copay</u> /fill maximum \$50 <u>copay</u> /fill retail; 20% <u>coinsurance</u> , minimum \$50 <u>copay</u> /fill maximum \$100 <u>copay</u> /fill mail order. <u>Deductible</u> does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	<u>Preauthorization</u> is required, call 800-367-9938.
	Physician/surgeon fees	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Failure to preauthorize will result in \$250 penalty.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	-- None --
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate. This service is only available when emergency treatment is not available locally. Your physician must order the treatment and travel will only be covered to the nearest hospital providing the necessary medical care or treatment.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> services, call 800-367-9938.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Failure to preauthorize <u>out-of-network</u> services will result in \$250 penalty. Charges limited to semi-private room rates.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit for office visits; 20% <u>coinsurance</u> for day treatment and partial hospitalization. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	-- None --
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Out-of-network</u> Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency.</p> <p><u>Preauthorization</u> is required for <u>out-of-network</u> services, call 800-367-9938.</p> <p>Failure to preauthorize <u>out-of-network</u> services will result in \$250 penalty.</p> <p>Charges limited to semi-private room rates.</p>
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Cost sharing does not apply for preventive <u>screenings</u>.</p> <p>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Up to 40 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u>).
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Up to 60 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u> for medical and mental health conditions).

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)	
				<p><u>Preauthorization</u> may be required for certain services to avoid a \$250 penalty.</p> <p>Call 800-367-9938 to confirm if <u>preauthorization</u> is required. Failure to preauthorize will result in \$250 penalty.</p> <p><u>Out-of-network</u> Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency.</p> <p><u>Out-of-network</u> inpatient services are not covered, unless medical emergency.</p>
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Up to 60 visits/calendar year (combined maximum for <u>in-network</u> and <u>out-of-network</u> for medical and mental health conditions).</p> <p><u>Preauthorization</u> is required, call 800-367-9938.</p> <p>Failure to preauthorize will result in \$250 penalty.</p> <p><u>Out-of-network</u> inpatient services are not covered, unless medical emergency.</p>
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Maximum of 60 inpatient days per year.</p> <p>Maximum of 60 outpatient visits per year (combined maximum for <u>in-network</u> and <u>out-of-network</u>).</p>

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)	
				<u>Out-of-network</u> inpatient services are not covered, unless medical emergency.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covered if terminally ill. <u>Preauthorization</u> is required for <u>inpatient</u> services, call 800-367-9938. Failure to preauthorize <u>inpatient</u> services will result in \$250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	\$250 annual maximum; administered separately by Professional Benefit Administrators, Inc. <u>Deductible</u> does not apply.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge for children under 19, <u>deductible</u> does not apply; No charge after \$50 <u>deductible</u> for children 19 and over.	20% <u>coinsurance</u> after \$50 <u>deductible</u> ; <u>Deductible</u> does not apply for children under 19.	Coverage is limited to 2 exams/year. Administered separately by Delta Dental of Illinois.

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except as required by the ACA)

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

- Acupuncture (Covered under spinal manipulation benefit and smoking cessation benefit if prescribed by a physician)
- Bariatric surgery (Based on meeting criteria for life-threatening obesity)
- Chiropractic care (Up to 60 treatments or \$1,000 per year)
- Dental care (Adult) (Up to \$1,500 per year under separately administered plan)
- Hearing aids (Up to \$5,000 per lifetime; limit does not apply to exams)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) (Up to \$250 for all vision benefits combined under separately administered plan)
- Routine foot care (Up to \$500 per year for orthotics)

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. 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: the Fund Office at 1-866-692-0860 or at www.ncilhwhf.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.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington Street, 4th Floor, Springfield, Illinois 62767, 1-866-445-5364, <http://www.insurance.illinois.gov>, DOL.Director@illinois.gov.

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 1-866-692-0860.

-----*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 \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$1,750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

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

- The plan's overall deductible \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$70
Copayments	\$260
Coinsurance	\$1,360
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$1,760

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

- The plan's overall deductible \$750
- Specialist cost sharing \$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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$390
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,160

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.