NCIL H & W Fund: BCBS: Actives

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.ncilhwf.com** or by calling **1-866-692-0860**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** person/**$1,000** family; Out-of-Network: **$1,000** person/**$3,000** family. Doesn't apply to In-Network preventive care, prescription drugs, outpatient surgery, second surgical opinion, dental, vision, hearing.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** person/**$100** family Dental. 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.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network Medical - **$2,500** person/**$7,500** family; In-Network Prescription Drugs - **$4,100** person/**$5,700** family. Out-of-Network - unlimited.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance billing, expenses not covered, charges for dental, vision, hearing or above a maximum benefit, prescription drug co-pays (included in prescription drug out-of-pocket limit).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call **1-866-692-0860 or visit us at www.ncilhwf.com**.

If you aren't clear about any of the underlined terms used in this form, 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:
Does this plan use a network of providers?	Yes. For a list of participating **providers**, go to www.bcbsil.com or call 1-800-810-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	50% co-insurance	None
	Specialist visit	$20 co-pay	50% co-insurance	None
	Other practitioner office visit	$15 co-pay for spinal manipulation	50% co-insurance	Coverage is limited to 60 visits up to $1,000/year for chiropractic.
	Preventive care/ screening/immunization	No charge	Not covered	None

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic formulary drugs	$10 co-pay retail, $20 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Brand formulary drugs	$20 co-pay retail, $40 co-pay mail order	100% coinsurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Non-formulary drugs	$35 co-pay retail, $70 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	Deductible not applied.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	Deductible not applied.
If you need immediate medical attention	Emergency room services	$200 co-pay	$200 co-pay	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	None
	Urgent care	20% co-insurance	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Pre-authorization is required. Failure to pre-authorize will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fee	20% co-insurance	50% co-insurance	None

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay	50% co-insurance	None
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	Must call MAP to preauthorize or $250 penalty.
	Substance use disorder outpatient services	$20 co-pay	50% co-insurance	None
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	Must call MAP to preauthorize or $250 penalty.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	50% co-insurance	None
	Delivery and all inpatient services	20% co-insurance	50% co-insurance	Charges limited to semi-private room rates.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Up to 40 visits/calendar year.
	Rehabilitation services	20% co-insurance	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. You must pay 100% of out-of-network inpatient services.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services. You must pay 100% of all Habilitation services.
	Skilled nursing care	20% co-insurance	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. Failure to preauthorize results in $250 penalty. You must pay 100% of out-of-network inpatient services.
	Durable medical equipment	20% co-insurance	50% co-insurance	Not for use as comfort or convenience item.
	Hospice service	20% co-insurance	50% co-insurance	None
If your child needs dental or eye care	Eye exam	No charge	No charge	Up to age 19.
	Glasses	No charge	No charge	Up to age 19. $250 annual maximum.
	Dental check-up	No charge	20% co-insurance	Up to age 19. Coverage is limited to 2 exams/year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (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)
- Hearing aids (Up to $5,000 lifetime)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) Up to $250 for all vision benefits combined)
- Routine foot care (Up to $500 per year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-866-692-0860. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-866-692-0860 or at **www.ncilhwf.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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Balance billing, expenses

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,210
- **Patient pays** $2,330

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$70
Co-insurance	$1,260
Limits or exclusions	$0
Total	**$2,330**

Note: Newborn charges are subject to their own deductible and co-insurance.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Co-pays	$940
Co-insurance	$0
Limits or exclusions	$300
Total	**$1,340**

Education is an excluded service.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-866-692-0860** or visit us at www.ncilhwf.com.
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NCIL H & W Fund: HFN: Actives

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.ncilhwf.com** or by calling **1-866-692-0860**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	EPO: **$100** person/**$200** family; PPO: **$500** person/**$1,000** family; Out-of-Network: **$1,000** person/**$3,000** family. Doesn't apply to preventive care, prescription drugs, outpatient surgery, second surgical opinion, dental, vision, hearing.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** person/**$100** family Dental. 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.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network-EPO Hospital or PPO Medical - **$2,500** person/**$7,500** family; In-Network Prescription Drugs - **$4,100** person/**$5,700** Family. Out-of-Network - unlimited.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance billing, expenses not covered, charges for dental, vision, hearing or above a maximum benefit, prescription drug co-pays (included in prescription drug out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of participating **providers**, call 1-800-295-5444 or see www.hfninc.com: type in client code (NCILF), select CHC, click Next.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use EPO/PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use an EPO/PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	50% co-insurance	None
	Specialist visit	$20 co-pay	50% co-insurance	None
	Other practitioner office visit	$15 co-pay for spinal manipulation	50% co-insurance	Coverage is limited to 60 visits up to $1,000/year for chiropractic.
	Preventive care/ screening/immunization	No charge	Not covered	None

Common Medical Event	Service You May Need	Your Cost if You Use an EPO/PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No charge for EPO; 20% co-insurance for PPO	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	No charge for EPO; 20% co-insurance for PPO	50% co-insurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic formulary drugs	$10 co-pay retail, $20 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Brand formulary drugs	$20 co-pay retail, $40 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Non-formulary drugs	$35 co-pay retail, $70 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance; no charge if EPO hospital	50% co-insurance	Deductible not applied.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	Deductible not applied.
If you need immediate medical attention	Emergency room services	$200 co-pay	$200 co-pay	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	None
	Urgent care	20% co-insurance	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance; no charge if EPO hospital	50% co-insurance	Pre-authorization is required. Failure to pre-authorize will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fee	20% co-insurance	50% co-insurance	None

Common Medical Event	Service You May Need	Your Cost if You Use an EPO/PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay	50% co-insurance	None
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	Must call MAP to preauthorize or $250 penalty.
	Substance use disorder outpatient services	$20 co-pay	50% co-insurance	None
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	Must call MAP to preauthorize or $250 penalty.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	50% co-insurance	None
	Delivery and all inpatient services	20% co-insurance; 0% co-insurance EPO hospital charges only	50% co-insurance	Charges limited to semi-private room rates.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Up to 40 visits/calendar year.
	Rehabilitation services	No cost inpatient, $25 co-pay outpatient	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. Failure to preauthorize results in $250 penalty. You must pay 100% of out-of-network inpatient services.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services. You must pay 100% of all Habilitation services.
	Skilled nursing care	20% co-insurance	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. Failure to preauthorize results in $250 penalty. You must pay 100% of out-of-network inpatient services.
	Durable medical equipment	20% co-insurance	50% co-insurance	Not for use as comfort or convenience item.
	Hospice service	20% co-insurance	50% co-insurance	None
If your child needs dental or eye care (up to age 19)	Eye exam	No charge	No charge	None
	Glasses	No charge	No charge	$250 annual maximum.
	Dental check-up	No charge	20% co-insurance	Coverage is limited to 2 exams/year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (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)
- Hearing aids (Up to $5,000 lifetime)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) Up to $250 for all vision benefits combined)
- Routine foot care (Up to $500 per year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-692-0860. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-866-692-0860 or at **www.ncilhwf.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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,730
- **Patient pays** $1,810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$70
Co-insurance	$740
Limits or exclusions	$0
Total	**$1,810**

Note: If you do not use an EPO Hospital, the amount of co-insurance you would pay would be $1,260 for a total of $2,330. Newborn charges are subject to their own deductible and coinsurance.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Co-pays	$940
Co-insurance	$0
Limits or exclusions	$300
Total	**$1,340**

Education is an excluded service.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-866-692-0860** or visit us at www.ncilhwf.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-866-692-0860** to request a copy.

NCIL H & W Fund: Health Alliance Actives

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.ncilhwf.com** or by calling **1-866-692-0860**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** person/**$1,000** family; Out-of-Network: **$1,000** person/**$3,000** family. Doesn't apply to In-Network preventive care, prescription drugs, outpatient surgery, second surgical opinion, dental, vision, hearing.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** person/**$100** family Dental. 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.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network Medical - **$2,500** person/**$7,500** family; In-Network Prescription Drugs - **$4,100** person/**$5,700** family. Out-of-Network - unlimited.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance billing, expenses not covered, charges for dental, vision, hearing or above a maximum benefit, prescription drug co-pays (included in prescription drug out-of-pocket limit).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of participating **providers**, go to www.healthalliance.org or call 1-800-322-7451.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	50% co-insurance	None
	Specialist visit	$20 co-pay	50% co-insurance	None
	Other practitioner office visit	$15 co-pay for spinal manipulation	50% co-insurance	Coverage is limited to 60 visits up to $1,000/year for chiropractic.
	Preventive care/ screening/immunization	No charge	Not covered	None

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic formulary drugs	$10 co-pay retail, $20 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Brand formulary drugs	$20 co-pay retail, $40 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
	Non-formulary drugs	$35 co-pay retail, $70 co-pay mail order	100% co-insurance (retail & mail order)	Covers up to a 34-day supply (retail); up to 90-day supply (mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	Deductible not applied.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	Deductible not applied.
If you need immediate medical attention	Emergency room services	$200 co-pay	$200 co-pay	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	None
	Urgent care	20% co-insurance	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Pre-authorization is required, call Health Alliance at 1-800-322-7451. Failure to pre-authorize will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fee	20% co-insurance	50% co-insurance	None

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay	50% co-insurance	None
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	Must call Health Alliance to preauthorize or $250 penalty.
	Substance use disorder outpatient services	$20 co-pay	50% co-insurance	None
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	Must call Health Alliance to preauthorize or $250 penalty.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	50% co-insurance	None
	Delivery and all inpatient services	20% co-insurance	50% co-insurance	Charges limited to semi-private room rates.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Up to 40 visits/calendar year.
	Rehabilitation services	20% co-insurance	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. You must pay 100% of out-of-network inpatient services.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services. You must pay 100% of all Habilitation services.
	Skilled nursing care	20% co-insurance	50% co-insurance for outpatient services; out-of-network inpatient services are not covered.	Up to 60 days inpatient/60 visits outpatient per year. Failure to preauthorize results in $250 penalty. You must pay 100% of out-of-network inpatient services.
	Durable medical equipment	20% co-insurance	50% co-insurance	Not for use as comfort or convenience item.
	Hospice service	20% co-insurance	50% co-insurance	None
If your child needs dental or eye care (up to age 19)	Eye exam	No charge	No charge	None
	Glasses	No charge	No charge	$250 annual maximum.
	Dental check-up	No charge	20% co-insurance	Coverage is limited to 2 exams/year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (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)
- Hearing aids (Up to $5,000 lifetime)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) Up to $250 for all vision benefits combined)
- Routine foot care (Up to $500 per year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-692-0860. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-866-692-0860 or at www.ncilhwf.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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,210
- **Patient pays** $2,330

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$70
Co-insurance	$1,260
Limits or exclusions	$0
Total	**$2,330**

Note: Newborn charges are subject to their own deductible and co-insurance.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Co-pays	$940
Co-insurance	$0
Limits or exclusions	$300
Total	**$1,340**

Education is an excluded service.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
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