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 1-847-827-1029. 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 1-847-827-1029 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** per individual/**$450** per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, second and third opinions, dental services, vision services, imaging provided in-network, prescription drugs, and private-duty nursing 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. **$10** per individual/**$30** per family for dental. There are 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: $1,000** per individual/**$1,500** per family **Prescription Drugs: $8,200** per individual/**$16,900** per family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain precertification for services, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com (select "PPO Plus") or call 1-800-810-2583 for a list of network providers; for dental providers see www.dnoa.com or call 1-866-522-6758; for vision providers see www.eyemedvisioncare.com or call 1-866-723-0513; for hearing call Amplifon (formerly HearPO) at 1-888-432-7464; for MRI/CT/PET Scans call Absolute Solutions at 1-800-321-5040 or www.absolutedx.com.	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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance	30% coinsurance after additional $5 deductible	None
	Specialist visit	20% coinsurance	30% coinsurance after additional $5 deductible	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Adult physical limited to one every 12 months. You may have to pay for services that the plan does not consider preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge. Deductible does not apply.	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	20% coinsurance retail; $15 copay per fill mail order & Maintenance Care. Deductible does not apply.	Not covered	Covers up to a 30-day supply at retail; up to a 90-day supply if using mail-order or Maintenance Care at CVS; two-fill limit of maintenance drugs at retail. This includes oral contraceptives. Your cost sharing does not count toward the out-of-pocket limit. No charge for FDA-approved generic preventive drugs, including contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs	20% coinsurance retail; $40 copay per fill mail order & Maintenance Care if no generic available, $60 copay per fill if generic available. Deductible does not apply.	Not covered	
	Non-preferred brand drugs	20% coinsurance retail; $40 copay per fill mail order & Maintenance Care if no generic available, $60 copay per fill if generic available. Deductible does not apply.	Not covered	
	Specialty drugs	20% coinsurance retail; $40 copay per fill mail order & Maintenance Care if no generic available, $60 copay per fill if generic available. Deductible does not apply.	Not covered	Precertification is required to avoid non-payment of benefits. Covers up to a 30-day supply at retail; up to a 90-day supply if using mail-order or Maintenance Care at CVS; two-fill limit of maintenance drugs at retail. Your cost sharing does not count toward the out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance in outpatient hospital setting; not covered in outpatient surgical facility	Precertification is required for surgeries of $5,000 or more to avoid $200 noncompliance penalty. For precertification, call Valenz at 1-800-367-9938.
	Physician/surgeon fees	20% coinsurance	20% coinsurance in outpatient hospital setting; not covered in outpatient surgical facility	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance after $50 deductible	20% coinsurance after $50 deductible	No charge for first aid within 72 hours of injury up to $300 after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance after additional $250 deductible	Precertification is required to avoid $200 noncompliance penalty. For precertification, call Valenz at 1-800-367-9938.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance; additional $5 deductible also applies to office visits	None
	Inpatient services	20% coinsurance	30% coinsurance after additional $250 deductible	Precertification is required to avoid $200 noncompliance penalty. For precertification, call ComPsych at 1-877-327-7798.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery charges are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	90 shifts for private-duty nursing per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Precertification required for physical therapy if treatment exceeds 26 visits per calendar year. Occupational therapy limited to 26 visits per calendar year. Speech therapy limited to 26 visits per calendar year. Custodial care is not covered.
	Habilitation services	20% coinsurance	20% coinsurance	Custodial care is not covered.
	Skilled nursing care	20% coinsurance	30% coinsurance	Maximum of 90 days per individual per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Precertification is required for equipment of $5,000 or more to avoid non-payment of benefits. For precertification, call Valenz at 1-800-367-9938.
	Hospice services	20% coinsurance	30% coinsurance	Precertification is required to avoid nonpayment of benefits. For precertification, call Valenz at 1-800-367-9938.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge up to $30. Deductible does not apply.	Limited to one exam per calendar year. Vision benefits separately administered by EyeMed.
	Children's glasses	Frames: no charge up to $100; you pay the remaining amount at a 20% discount on the retail price Single vision lenses: No charge after $5 copay per set. Deductible does not apply.	Frames: No charge up to $30 Lenses: No charge up to $50. Deductible does not apply.	Limited to one pair of frames and lenses per calendar year. Bifocals and trifocals subject to a higher in-network copay than single vision lenses. Vision benefits separately administered by EyeMed.
	Children's dental check-up	No charge. Deductibles do not apply.	No charge. Deductibles do not apply.	Limited to one check-up every 6 months. Separately administered by Dental Network of America.

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.)		
• Acupuncture • Cosmetic surgery • Gene and Cellular Therapy Treatments and Gene and Cellular Therapy Prescription Drugs	• Long-term care	• Non-emergency (and emergency) care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Adults Only; once per lifetime if prerequisites are met) • Chiropractic care ($2,000 per individual per calendar year) • Dental care (Adults age 19 and older) ($1,000 per individual per calendar year. Separately administered by Dental Network of America.)	• Hearing aids (No charge for first $500; thereafter, 20% coinsurance in-network and 30% coinsurance out-of-network every 3 calendar years) • Infertility treatment ($5,000 per calendar year/$25,000 per individual per lifetime) • Private-duty nursing (90 shifts per individual per calendar year)	• Routine eye care (Adult) (exam and materials limits apply. Separately administered by EyeMed.) • Routine foot care • Weight loss programs (Adult only) (one non-preventive treatment course per lifetime for obesity if prerequisites are met and as required by health reform law)

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Ms. Julie A. Rachal, Fund Manager, Roofers' Unions Welfare Trust Fund, 2021 Swift Drive, Suite B, Oak Brook, Illinois 60523, Telephone: 1-847-827-1029. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-847-827-1029.

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	**$150**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$850
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$1,380**

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

The plan's overall deductible	**$150**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$680**

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