Southern Illinois Laborers & Employers Health & Welfare Fund: Plans A & C – Active Participants

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Employees & Dependents
Plan Type: HMO/PPO

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, go to www.silehw.org or call (618) 998-1300. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (618) 998-1300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network and Out-of-Area: $850 per Individual/$2,550 per Family Out-of-Network: $4,000 per Individual/$12,000 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. "Out of Area" means out-of-network coverage while traveling, court-ordered coverage for a dependent, or of lack of a qualified provider within 100 miles of the Participant, as explained in the SMM dated August 1, 2017.
Are there services covered before you meet your deductible?	Yes. In-Network and Out-of-Area Preventive, Hearing, Smoking Cessation, Vision and Prescription Benefits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $50 Dental deductible,	You must pay all 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 In-Network and Out-of-Area: $5,250 per Individual/$10,500 per Family Pharmacy In-Network: $1,900 per Individual/$3,800 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, they have to meet their own out-of-pocket limits until the overall the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't 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 or call (800) 624-2356 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network and Out-of-Area 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	55% coinsurance	----------none----------
	Specialist visit			
	Preventive care/screening/ immunization	No charge	55% coinsurance	In-Network and Out-of-Area – No deductible. Limited to 1 physical exam (including, but not limited to, pap smear, gynecological exam and prostrate exam) per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For specific benefits and limitations, see Article 7 of the SPD.*
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	55% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			

*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network and Out-of-Area 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 by calling the Fund Office at (618) 998-1300.	Generic drugs	Retail (30 days) – Greater of $10 or 25% coinsurance, $20 max Mail order (90 days) - Greater of $20 or 25% coinsurance, $50 max	Not covered	No deductible on Prescription Benefits. If a participant chooses to utilize a brand drug when a generic equivalent is available, the participant will be required to pay the applicable $40 or $75 copayment plus the difference in cost between the brand drug and generic.
	Preferred brand drugs	Retail (30 days) – Greater of $35 or 30% coinsurance, $40 max Mail order (90 days) - Greater of $70 or 30% coinsurance, $75 max		
	Non-preferred brand drugs	Retail (30 days) – Greater of $45 or 35% coinsurance, $70 max Mail order (90 days) - Greater of $90 or 35% coinsurance, $100 max		
	Specialty drugs	SPECIALTY PHARMACY 30% coinsurance, $225 max per prescription PHYSICIAN OR FACILITY 30% coinsurance, $225 max per course of treatment, subject to deductible.	Not covered	Cancer related drugs are excluded from the 30% coinsurance. The first dialysis treatment of each month that includes bio-injectable or specialty medications is subject to $225 copayment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	55% coinsurance	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance after $175 copayment for non-accidents		$175 copayment waived if patient is immediately admitted to hospital.
	Emergency medical transportation	20% coinsurance	55% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network and Out-of-Area Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care			----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	55% coinsurance	Semi-private room only.
	Physician/surgeon fees			----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	55% coinsurance	----------none----------
	Inpatient services			
If you are pregnant	Office visits	20% coinsurance	55% coinsurance	Post-natal services, delivery and inpatient services for Employee and Spouse only. Cost sharing does not apply to in-network and out-of-area preventive services. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	55% coinsurance	Limit of 100 visits per calendar year. Up to 4 hours = 1 visit.
	Rehabilitation services			Limit of 50 combined visits per year for speech, occupational and physical therapy. Speech therapy covered only for certain conditions. See SPD Section 2.22 for more information.*
	Habilitation services			Limit of 50 combined visits per year for speech, occupational and physical therapy See Article 7 of the SPD for other exclusions and limitations.*
	Skilled nursing care			Limit of 30 days per year.
	Durable medical equipment			Wheelchair paid at 50% up to $1,000. All other equipment rental covered up to the purchase price. See SPD Section 2.09 for criteria.*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network and Out-of-Area Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services			Limit of 185 days per year. Must submit a Hospice Care Plan
If your child needs dental or eye care	Children's eye exam	No charge		Includes 1 routine eye exam each year up to $100.
	Children's glasses			Includes 1 set of frames and lenses or contacts up to $150 per year.
	Children's dental check-up			One exam and cleaning every 6 months.

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
- Bariatric surgery
- Cosmetic surgery (unless necessary as a result of an accident)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

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

- Chiropractic care (up to 20 visits/year)
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 (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 (618) 998-1300 or 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

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:

Para obtener asistencia en Español, llame al (618) 998-1300.

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	$850
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,400**

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

The plan's overall deductible	$850
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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,700**

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

The plan's overall deductible	$850
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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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