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, 1-708-429-0046. 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 1-708-429-0046 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person or **$1,500** 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. Some diagnostic and imaging tests (Absolute Solutions PPO Network only), Disease Management Program, vision benefits, in-network prescription drugs, and preventive dental care 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. **$25** per person for dental (excluding preventive care). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: **$2,500** per person; Out-of-network: **$4,375** per person	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, cost sharing under the dental and prescription drug programs, vision benefits separately administered by United Healthcare, 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 1-800-810-2583 for a list of network providers. For a list of dental providers, visit www.guardianlife.com or call 1-866-302-4542. For a list of vision providers, visit www.myuhcvision.com or call 1-800-839-3242. For a list of prescription drug providers, visit www.optumrx.com or call 1-855-577-6319.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	35% coinsurance	Teleconference visits covered at the same cost sharing as an office visit
	Specialist visit	20% coinsurance	35% coinsurance	
	Preventive care/screening/ immunization	20% coinsurance	35% coinsurance	Limited to one physical exam per year. Immunizations limited to individuals age 18 and under.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No charge (only if through Absolute Solutions Network) and deductible does not apply; 20% coinsurance for other in-network providers. Lab tests: 20% coinsurance	35% coinsurance	Call 800-321-5040 or visit www.absolutedx.com to find a provider in the Absolute Solutions Network.
	Imaging (CT/PET scans, MRIs)	No charge (only if through Absolute Solutions Network); deductible does not apply. 20% coinsurance for other in-network providers.	35% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs	$10 copayment per fill at retail; $20 copayment per fill through mail order. Deductible does not apply.	35% coinsurance.	Retail covers up to 90-day supply in the form of three separate 30-day prescriptions. May be ordered together, but each 30-day prescription is subject to the copay. Mail order is a 90-day supply. If a non-participating pharmacy is used, the Major Medical deductible and coinsurance will apply. Your cost sharing does not count toward the plan's 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)	
	Preferred brand drugs	Greater of $15 copayment per fill or 15% coinsurance at retail, up to a maximum of $40 retail. Deductible does not apply. Greater of $30 copayment per fill or 15% coinsurance through mail order, up to a maximum of $80. Deductible does not apply.	35% coinsurance	Retail covers up to 90-day supply in the form of three separate 30-day prescriptions. May be ordered together, but each 30-day prescription is subject to the copay. Mail order is a 90-day supply. If brand is dispensed when generic is available, participant may owe the difference plus the brand copay or coinsurance. If a non-participating pharmacy is used, the Major Medical deductible and coinsurance will apply. Your cost sharing does not count toward the plan's out-of-pocket limit.
	Specialty drugs	Greater of $25 copayment per fill or 15% coinsurance at retail, up to a maximum of $50. Deductible does not apply. Greater of $50 copayment per fill or 15% coinsurance through mail order, up to a maximum of $100. Deductible does not apply.	Not covered	Preauthorization required. Contact Med-Care Management at 1-800-367-1934 to preauthorize. Your cost sharing does not count toward the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	The plan does not cover expenses incurred at an outpatient surgical facility unless the facility is in-network. This limitation does not apply to outpatient surgery in a hospital or a physician's office. Notification required within 48 hours of non-emergency outpatient surgery. Contact Med-Care Management at 1-800-367-1934 to provide notification.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	

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 immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Notification required within 48 hours of emergency hospital admission. Contact Med-Care Management at 1-800-367-1934 to provide notification.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Preauthorization is required for non-emergency admissions. Notification required within 48 hours of emergency hospital admission. Contact Med-Care Management at 1-800-367-1934 to preauthorize. Semi-private room rate.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	35% coinsurance	Teleconference visits covered at the same cost sharing as an office visit Preauthorization is recommended. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Inpatient services	20% coinsurance	35% coinsurance	Preauthorization is required for non-emergency admissions. Notification required within 48 hours of emergency hospital admission. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
If you are pregnant	Office visits	20% coinsurance	35% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	

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 help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Limited to 30 visits per calendar year and 12 hours per 24-hour period for licensed nurse and 8 hours per 24-hour period for home health aide. Preauthorization is required. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Rehabilitation services	20% coinsurance	35% coinsurance	Preauthorization required for inpatient services at least 48 hours before the admission. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Habilitation services	20% coinsurance	35% coinsurance	Speech therapy limited to 25 visits per calendar year. Preauthorization required for inpatient services at least 48 hours before the admission. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Skilled nursing care	20% coinsurance	35% coinsurance	Preauthorization required for inpatient services at least 48 hours before the admission. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Durable medical equipment	20% coinsurance	35% coinsurance	Preauthorization is required for amounts over $500. Contact Med-Care Management at 1-800-367-1934 to preauthorize.
	Hospice services	20% coinsurance	35% 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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge. Deductible does not apply. Plan limit of $40/exam does not apply to dependent children age 18 and under.	Coverage is limited to one exam every 12 months. A second exam every 12 months is covered for dependent children up to age 13 in the event of a prescription change of .5 diopter or greater. Administered separately by United Healthcare. You must pay and then file a claim for reimbursement for out-of-network expenses. You may opt-out of vision coverage annually.
	Children's glasses	No charge on covered frames up to $130. Deductible does not apply.	No charge up to $45 for frames and up to $40, $60, or $80 depending on type of lenses selected. Deductible does not apply.	Coverage is limited to one pair of glasses every 12 months. A second pair of glasses every 12 months is covered for dependent children up to age 13 in the event of a prescription change of .5 diopter or greater. Administered separately by United Healthcare. You must pay and then file a claim for reimbursement for out-of-network expenses. Contact lenses covered instead of frames and lenses up to $105 every 12 months. Medically necessary contacts covered at 100% (in-network). Medically necessary contacts covered at 100% up to $210 (out-of-network). You may opt-out of vision coverage annually.
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Checkups/cleanings (preventive care) limited to two visits per year for dependents under age 19. Dependents age 19 and over subject to $750 maximum per person per year. You may opt-out of dental coverage annually.

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 (except for accidents, congenital anomaly, and after mastectomy)
- Hearing aids
- Infertility treatment
- Long-term care
- 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 (subject to calendar limit of $2,500 and $100 per visit after the first visit)
- Dental care (Adult) ($1,000 maximum per year for members and $750 maximum per year for spouse/dependents)
- Non-emergency care when traveling outside the U.S. (unless related to occupation)
- Routine eye care (Adult) (under separately administered plan)
- 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: the U.S. 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 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: the Fund Manager, Beer Industry - Local Union No. 703 Health and Welfare Fund, 18660 Graphic Drive, Suite 202, Tinley Park, IL 60477 at (708) 429-0046. 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.

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	$500
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	$500
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$110
The total Peg would pay is	**$2,620**

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

The plan's overall deductible	$500
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	$500
Copayments	$130
Coinsurance	$870
What isn't covered	
Limits or exclusions	$430
The total Joe would pay is	**$1,930**

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

The plan's overall deductible	$500
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	$500
Copayments	$10
Coinsurance	$460
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$970**

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