Local 734 Welfare Fund / Pension Fund

6643 NORTH NORTHWEST HIGHWAY • CHICAGO, ILLINOIS 60631-1360 • Tel.: 773-594-2810
Fax: 773-631-3824

Dear Participant,

Enclosed is a Summary of Benefits and Coverage ("SBC") for your health plan. The Affordable Care Act (health care reform) requires all health plans to prepare and distribute these documents.

What is an SBC?

The Affordable Care Act requires insured and uninsured health care plans to provide consumers with a standardized document using consistent terminology describing the key features of the plan. The content, formatting requirements and appearance are strictly regulated to allow easy comparison of coverage options between plans.

Who Needs an SBC?

SBCs are aimed at individuals who are shopping for health insurance or who have to choose between two or more plans offered through their employer. It is meant to help people compare between various coverage and plan options.

Then Why Am I Receiving an SBC?

The regulations require us to send you an SBC. However, your Plan provides the coverage outlined in your Summary Plan Description—that is the Plan. There are no options from which you have to choose.

Is an SBC an Accurate Description of My Plan?

We made every attempt to provide accurate information on the SBC, but it contains only certain information and only in the manner and format dictated by the regulations. It does NOT contain a complete explanation of how benefits are determined, nor does it contain all Plan benefits, limitations, exclusions, eligibility rules, etc.

Does Receiving an SBC Guarantee Coverage or Eligibility?

No. The SBC is NOT a guarantee of coverage or eligibility. It is for comparison purposes only. You should refer to your Summary Plan Description booklet for a more complete description of your Plan and its eligibility rules.

Will I Receive Other SBCs?

Yes. They will be revised and redistributed as needed. They are also available upon request.

Sincerely,

The Fund Office

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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.bakerydrivers-local734.com** or by calling **1-773-594-2810.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per person/**$1,000** per family. Does not apply to prescription drugs, speech therapy or chiropractic care.	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, **$250** for out-of-network hospitalization. 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. **$2,500** per person/**$5,000** per family.	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?	Prescription drugs, balance-billed 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**.
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.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of participating providers.	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 the plan doesn't cover are listed on page 5. See your policy or plan documents 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 (in-network) **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an in-network 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-insurance	20% co-insurance	-------------------none-------------------
	Specialist visit	20% co-insurance	20% co-insurance	Benefit maximum for non-surgical podiatric treatment is $750/year. Benefit maximum for non-surgical TMJ treatment is $750/year. Podiatry and TMJ treatment must be pre-certified.
	Other practitioner office visit	20% co-insurance	20% co-insurance	Benefit maximum for chiropractic care is $1,500/year only applies to adjustments, manipulations and office visits. Must be pre-certified. Acupuncture limited to 12 visits/year.
	Preventive care/screening/immunization	No charge	20% co-insurance	-------------------none-------------------
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% co-insurance	20% co-insurance	-------------------none-------------------

Common Medical Event	Services You May Need	Your cost if you use an in-network Provider	Your cost if you use an out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	10% co-insurance, with $5 minimum and $200 maximum per co-pay	Not covered	Prescription drug out-of-of-pocket limit is $3,000/person, $5,000/family per year. You must use mail-order or 90-day walk-in for maintenance or long-term drugs. If you choose a brand over an available generic, you must pay difference in cost in addition to your co-pay. Prescription drug program cannot be used by persons with other primary group drug coverage.
	Formulary brand drugs	20% co-insurance, with $5 minimum and $200 maximum per co-pay	Not covered	
	Non-formulary brand drugs	30% co-insurance, with $5 minimum and $200 maximum per co-pay	Not covered	
	Lifestyle drugs (drugs for erectile dysfunction or weight loss, and medically necessary proton pump inhibitors and non-sedating antihistamines)	40% co-insurance, with $5 minimum and $200 maximum per co-pay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not covered	Must be pre-certified.
	Physician/surgeon fees	20% co-insurance	20% co-insurance	
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	-------------------none-------------------
	Emergency medical transportation	20% co-insurance	20% co-insurance	
	Urgent care	20% co-insurance	20% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	20% co-insurance, additional $250 deductible	Must be pre-certified.
	Physician/surgeon fee	20% co-insurance	20% co-insurance	

Common Medical Event	Services You May Need	Your cost if you use an in-network 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-insurance	20% co-insurance	-------------------none-------------------
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	Must be pre-certified.
	Substance use disorder outpatient services	20% co-insurance	20% co-insurance	-------------------none-------------------
	Substance use disorder inpatient services	20% co-insurance	20% co-insurance	Must be pre-certified.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	20% co-insurance	Baby's charges are only covered if the baby is a covered dependent of the employee.
	Delivery and all inpatient services	20% co-insurance	20% co-insurance, additional $250 deductible	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	Must be pre-certified.
	Rehabilitation services	20% co-insurance	20% co-insurance	Must be pre-certified. If speech therapy is not due to an organic cause, benefits are limited to $1,500/year and $3,000/lifetime. Massage therapy is limited to 12 visits/year (not covered unless prescribed by a doctor as accompanied by other physical therapy modalities). Physical therapy limited to 40 visits/year.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance	20% co-insurance	Must be pre-certified.
	Durable medical equipment	20% co-insurance	20% co-insurance	Must be pre-certified.
	Hospice service	20% co-insurance	20% co-insurance	-------------------none-------------------
If your child needs dental or eye care	Eye exam	No charge		-------------------none-------------------
	Glasses	Amount in excess of $50 for frame and $40 for lenses		-------------------none-------------------
	Dental check-up	10% co-insurance	20% co-insurance	Note: A dental HMO plan is also offered.

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	• Private-duty nursing	• Routine foot care
• 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 up to 12 visits/year	• Bariatric surgery if coverage criteria met	• Chiropractic care up to $1,500/year only applies to adjustments, manipulations, and office visits.
• Dental care (Adult)	• Hearing aids up to $2,500 every 5 years, paid at 50%	• Non-emergency care when traveling outside the U.S., up to $250 in benefit payments
• Routine eye care (Adult)		

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 1-773-594-2810. 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 plan at 1-773-594-2810. You may also contact the U.S. Department of Labor, 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 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 1-773-594-2810.
Tagalog (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-773-594-2810.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-773-594-2810.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-773-594-2810.

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** $5,645
- **Patient pays** $1,895

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	$500
Co-pays	$35
Co-insurance	$1,360
Limits or exclusions	$0
Total	**$1,895**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,950
- **Patient pays** $1,450

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	$500
Co-pays	$330
Co-insurance	$320
Limits or exclusions	$300
Total	**$1,450**

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.