Local 734 Welfare Fund / Pension Fund

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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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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, visit www.bakerydrivers-local734.com or call 1-773-594-2810. 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 1-773-594-2810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/individual or **$1,000**/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 care is 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. **$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.
What is the out-of-pocket limit for this plan?	**$2,500** individual / **$5,000** 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 family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drugs, 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 1-800-810-2583 for a list of network providers.	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	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	Benefit maximums apply: $750/year for non-surgical podiatry is $750/year, $750/year for non-surgical TMJ treatment, $1,500/year for chiropractic adjustments, manipulations, and office visits, 12 visits/year for acupuncture. Podiatry, TMJ, chiropractic, and acupuncture must be preauthorized.
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need 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)	20% coinsurance	20% coinsurance	
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% coinsurance, with $5 minimum and $200 maximum per copay	Not covered	Prescription drug out-of-of-pocket limit is $3,000/person or $5,000/family per year. You must use mail-order or 90-day walk-in for long-term drugs. If you choose a brand over an available generic, you must pay difference in cost in addition to your copay. Minimum/maximum copays apply to retail and mail. Prescription drug program cannot be used by persons with other primary group drug coverage. Preauthorization is required for specialty drugs.
	Preferred brand drugs	20% coinsurance, with $5 minimum and $200 maximum per copay	Not covered	
	Non-preferred brand drugs	30% coinsurance, with $5 minimum and $200 maximum per copay	Not covered	
	Lifestyle drugs (drugs for erectile dysfunction or weight loss, and proton pump inhibitors and non-sedating antihistamines)	40% coinsurance, with $5 minimum and $200 maximum per copay	Not covered	
	Specialty drugs	Same as above	Not covered	

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	Not covered	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	Preauthorization is required.
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	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$250/visit copay, 20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Baby's charges are only covered if the baby is a covered dependent of the employee.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$250/visit copay, 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	20% coinsurance	Preauthorization is required. If speech therapy is not due to an organic cause, benefits are $1,500 annual max and $3,000 lifetime max. Physical therapy is limited to 40 visits/year. Massage therapy is limited to 12 visits/year (must be prescribed by a doctor and be part of a plan with other physical therapy modalities).
	Habilitation services	Not covered	Not covered	Not covered except for limited speech therapy benefits above
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required.
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization is required.

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	No charge	$500/year maximum for all vision services (paid at 100%).*
	Children's glasses	No charge	No charge	
	Children's dental check-up	10% coinsurance	20% coinsurance	Note: A dental HMO plan is also offered.**

** Adult vision benefit is 80% to $500 per year. ** Adult dental PPO plan has $1,500 annual maximum. The maximum does not apply to preventive services for children under age 19.*

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.)

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Abortion (preauthorization is required)
- 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 paid at 50% up to $2,500 every 5 years
- Non-emergency care when traveling outside the U.S., up to $250 in benefit payments
- Routine eye care (Adult)

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 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 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: 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.bakerydrivers-local734.com or call 1-773-594-2810.]

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 1-773-594-2810.]
[Tagalog (Tagalog): Kung kailangan ninyo 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 section.

[* For more information about limitations and exceptions, see the plan or policy document at www.bakerydrivers-local734.com or call 1-773-594-2810.]

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 *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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*	$20
Coinsurance	$2,230
What isn't covered	
Limits or exclusions**	$720
The total Peg would pay is	**$3,470**

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 *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments*	$1,150
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,730**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

* *Includes Rx.*
***Genetic tests and OTC vitamins excluded.*

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