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.local17fund.com or by calling 1-708-468-8000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** per person/**$600** per family per calendar year.	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. **$25** for dental care deductible. 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. **$4,000** per person for Non-PPO.	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?	Non-PPO co-pays, prescription drug co-pays, certain non-PPO expenses, premiums, 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 *specified* covered services, such as office visits.
Does this plan use a network of providers?	No. This Plan coordinates benefits with Medicare. Please see www.Medicare.gov for a list of Medicare participating providers.	This plan treats **providers** the same in determining payment for the same services.
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 this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**.)
- Your cost sharing under this plan does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost For Medicare Approved Expenses If You Use a Medicare Provider		Your Cost For Expenses Not Approved by Medicare	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge		$25 co-pay/office visit; 20% co-insurance	----------none----------**
	Specialist visit	No charge		$25 co-pay/office visit; 20% co-insurance	
	Other practitioner office visit	No charge		$25 co-pay/office visit; 20% co-insurance	Chiropractic care is limited to 18 visits per year per person.**
	Preventive care/screening/immunization	No charge		Not covered	Preventive care/screening/immunizations not covered by Medicare are not covered by the Plan.**
If you have a test	Diagnostic test (x-ray, blood work)	No charge		20% co-insurance	There is no charge for pre-admission testing and the deductible and co-insurance do not apply.**
	Imaging (CT/PET scans, MRIs)	No charge		20% co-insurance	----------none----------**
If you need drugs to treat your illness or condition		**Retail**	**Mail**		
	Generic drugs	$8 co-pay	$16 co-pay	25% after co-pay	$5,350 per person/$6,950 per family out-of-pocket maximum per calendar year. Mail order prescriptions are available for up to a 90-day supply. The Plan will permit an initial fill of a
	Brand drugs without generic	$20 co-pay	$50 co-pay	25% after co-pay	
	Brand drugs with generic	$50 co-pay	$150 co-pay	25% after co-pay	

Common Medical Event	Services You May Need	Your Cost For Medicare Approved Expenses If You Use a Medicare Provider		Your Cost For Expenses Not Approved by Medicare	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.caremark.com	Specialty drugs	$50 co-pay	$50 co-pay	$50 co-pay	maintenance prescription for 30-days and one refill for an additional 30-day supply at a retail pharmacy. Thereafter, the Participant must use the mail-order pharmacy to fill such prescriptions. A 90-day supply of a prescription drug that would otherwise be required to be filled by mail-order may be filled at a CVS retail pharmacy.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% co-insurance	Pre-certification required ($250 penalty).**
	Physician/surgeon fees	No charge		20% co-insurance	----------none----------**
If you need immediate medical attention	Emergency room services	No charge		$35 co-pay per emergency room visit	All emergency hospitalizations not covered by Medicare must be reported no later than the business day following admission ($150 penalty).**
	Emergency medical transportation	No charge		20% co-insurance	Emergency medical transportation not covered by Medicare is limited to necessary transportation provided by a hospital or a professionally licensed ambulance service: (1) from your home, the scene of an accident or a medical emergency to a hospital; (2) between hospitals; (3) between a hospital and a skilled nursing facility; or (4) from a hospital or skilled nursing facility to your home.**
	Urgent care	No charge		$25 co-pay/office visit; 20% co-insurance	----------none----------**

Common Medical Event	Services You May Need	Your Cost For Medicare Approved Expenses If You Use a Medicare Provider	Your Cost For Expenses Not Approved by Medicare	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge until Medicare lifetime reserve days are exhausted; 20% co-insurance thereafter	20% co-insurance	The daily room and board rate for expenses not approved by Medicare is limited to the semi-private daily room rate. The limitation does not apply if the private room is necessary for isolation purposes; pre-certification required ($250 penalty).**
	Physician/surgeon fee	No charge	20% co-insurance	----------none----------**
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	$25 co-pay/office visit; 20% co-insurance	If treatment provided in a hospital emergency room, then $35 co-pay applies. There is no charge for services after the $35 co-pay.**
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	No charge	$25 co-pay/office visit; 20% co-insurance	No charge for certain preventive care services.**
	Delivery and all inpatient services			----------none----------**
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	The home health care plan must be prescribed by a Physician in writing and pre-certification is required prior to the exhaustion of Medicare lifetime reserve days ($250 penalty).**
	Rehabilitation services	No charge	20% co-insurance	Cardiac rehabilitation is covered if approved by Medicare or if provided immediately following a hospital discharge, but only for Phase I and Phase II rehabilitation. Speech therapy not covered by Medicare is limited to the treatment of an illness or injury, or after corrective surgery for a congenital defect.**

Common Medical Event	Services You May Need	Your Cost For Medicare Approved Expenses If You Use a Medicare Provider	Your Cost For Expenses Not Approved by Medicare	Limitations & Exceptions
	Habilitation services	No charge	20% co-insurance	Habilitation services not covered by Medicare must be medically necessary and services cannot be rendered by a close relative or by a person who resides in the same household of the Participant.**
	Skilled nursing care	$0 (paid by Medicare) for first 20 days; $0 (paid by Plan) for 21st day through 45th day.	20% co-insurance	Pre-certification is required for expenses not approved by Medicare ($250 penalty).**
	Durable medical equipment	No charge	20% co-insurance	The replacement of equipment not covered by Medicare will follow Plan guidelines.**
	Hospice service	No charge	20% co-insurance	The Participant's life expectancy must not exceed 6 months from the day hospice care begins; pre-certification required ($250 penalty).**
If your child needs dental or eye care	Eye exam	50% of balance over $400 for eye exams, lenses and one pair of frames in conjunction with a new prescription*		*Payment is made on a reimbursement basis only. Claims must be filed within 24 months of incurring the expense.
	Glasses			
	Dental check-up	No charge*	No charge*	*No charge for preventive and diagnostic services. $2,000 per person/$8,000 per family calendar year limit will apply for all other covered services.**

** Amounts paid by the Retiree for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Retiree's VEBA account.

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.)

- Acupuncture (unless medically necessary)**
- Bariatric surgery**
- Cosmetic surgery (except for the repair of congenital defects of a child or for conditions resulting from accidental injuries due to Accidents or illnesses)**
- Long-term care (unless provided by a Skilled Nursing Facility as defined by the Plan)**
- 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.)

- Chiropractic care (limited to 18 visits per year per person)**
- Dental Care (Adult) ($25 per person/calendar year deductible applies to basic and restorative coverages; $600 per person calendar year maximum)**
- Hearing aids ($2,000 maximum/year per ear (limit does not apply to bone anchored hearing aids for Dependent Children under age 19); excludes replacement hearing aid within 36 months following the purchase of existing hearing aid, cost of replacing a lost or damaged hearing aid, hearing aid batteries, and the cost of eyeglass frames with a built-in hearing aid)**
- Infertility treatment ($50,000 per family maximum; limit does not apply to diagnostic tests and procedures done solely to identify the cause or causes of infertility)**
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) ($400 maximum benefit per year per person)**

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 1-708-468-8000. You may also contact your state insurance department, 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 1-708-468-8000. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit www.insurance.illinois.gov.

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:

Para obtener asistencia en Español, llame al 1-708-468-8000.

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** $7,380*
- **Patient pays** $160

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	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

Note: These numbers do not consider any possible reimbursement from your HRA account.

*Amount includes estimated amount paid by Medicare.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,000*
- **Patient pays** $400

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	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$80
Total	**$400**

Note: These numbers do not consider any possible reimbursement from your HRA account.

*Amount includes estimated amount paid by Medicare.

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.