 **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.lineco.org or by calling 1-800-323-7268.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible? | \$300 person/ \$600 family. Does not apply to preventive. | 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 hospital review program non-compliance and \$150 for emergency room visits. 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. \$1,625 person/ \$4,000 family for medical and \$1,000 person/ \$2,000 family for prescription drugs. | 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? | 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 <i>specific</i> 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. For mental health/substance abuse see www.beaconhealthoptions.com/ or call Beacon Health Option at 1-(800)-332-2191. | 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 . |

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at www.dol.gov/ebsa/healthreform or call 1-800-323-7268 to request a copy.

Line Construction Benefit Fund: Medicare-Secondary

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family Plan Type: PPO

- 
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* | 30% co-insurance | -----none----- |
| | Specialist visit | 20% co-insurance* | 30% co-insurance | -----none----- |
| | Other practitioner office visit | 50% co-insurance for spinal manipulations/adjustments (and related services) and 20% co-insurance* for acupuncture | | Coverage is limited to \$600 annual max for spinal manipulations/adjustments, including related services, and 12 visits/year for acupuncture. |
| | Preventive care/screening/immunization | No charge | 30% co-insurance | -----none----- |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge for first \$150/year, 20% co-insurance* thereafter | No charge for first \$150/year, 30% co-insurance thereafter | The \$150 benefit applies to employees and spouses only. |
| | Imaging (CT/PET scans, MRIs) | | | |

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Line Construction Benefit Fund: Medicare-Secondary

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family Plan Type: PPO

| 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.express-scripts.com . | Generic drugs | 20% co-pay, \$10 co-pay mail | Not covered | Coverage is limited to 30-day supply retail and 31-90-day supply mail. If generic substitution declined, you pay the difference in cost between the brand and generic equivalent. No coverage if step therapy program rules are not followed. Use of the mail-service pharmacy is mandatory for maintenance drugs after the original supply plus one refill. |
| | Preferred brand drugs | 20% co-pay retail, \$20 co-pay mail | Not covered | |
| | Non-preferred brand drugs | 20% co-pay retail, \$35 co-pay mail | Not covered | |
| | Specialty drugs | 1/3 mail co-pay | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance* | 30% co-insurance | Pre-certification and in-network providers required for bariatric & TMJ surgery or services are not covered. |
| | Physician/surgeon fees | 20% co-insurance* | 30% co-insurance | |
| If you need immediate medical attention | Emergency room services | 20% co-insurance* | 20% co-insurance | Additional \$150 deductible. |
| | Emergency medical transportation | 20% co-insurance* | 20% co-insurance | -----none----- |
| | Urgent care | 20% co-insurance* | 30% co-insurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-insurance* | 30% co-insurance | Additional \$250 deductible applies if inpatient confinement not pre-certified. Pre-certification and in-network providers required for bariatric & TMJ surgery or services are not covered. |
| | Physician/surgeon fee | 20% co-insurance* | 30% co-insurance | |

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Line Construction Benefit Fund: Medicare-Secondary

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: Family Plan Type: PPO

| 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* Primary network is through Beacon Health Options. | 30% co-insurance | Pre-certification is required for partial inpatient treatment, intensive outpatient treatment, psychological testing and electroconvulsive therapy or services are not covered. |
| | Mental/Behavioral health inpatient services | 20% co-insurance* Primary network is through Beacon Health Options. | 30% co-insurance | Additional \$250 deductible applies if inpatient confinement not pre-certified. Pre-certification is required for inpatient, residential and partial inpatient treatment and electroconvulsive therapy or services are not covered. |
| | Substance use disorder outpatient services | 20% co-insurance* Primary network is through Beacon Health Options. | 30% co-insurance | Pre-certification is required for intensive outpatient treatment, psychological testing or services are not covered. |
| | Substance use disorder inpatient services | 20% co-insurance* Primary network is through Beacon Health Options. | 30% co-insurance | Additional \$250 deductible applies if inpatient confinement not pre-certified. Pre-certification is required for inpatient, residential and partial inpatient treatment or services are not covered. |
| If you are pregnant | Prenatal and postnatal care | 20% co-insurance* | 30% co-insurance | No charge for in-network prenatal office visits for women. Maternity benefits are not provided for children (other than prenatal visits for children). |
| | Delivery and all inpatient services | 20% co-insurance* | 30% co-insurance | |

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Line Construction Benefit Fund: Medicare-Secondary

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family Plan Type: PPO

| 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 help recovering or have other special health needs | Home health care | 20% co-insurance | 30% co-insurance | Coverage is limited to 40 visits /year. |
| | Rehabilitation services | 20% co-insurance* | 30% co-insurance | Speech therapy allowable amount is \$90/visit, and plan allows 50 visits/year max. |
| | Habilitation services | Not covered | Not covered | Not covered |
| | Skilled nursing care | 20% co-insurance* | 30% co-insurance | Coverage is limited to 30-day annual max. |
| | Durable medical equipment | 20% co-insurance* | 30% co-insurance | -----none----- |
| | Hospice service | 20% co-insurance* | 30% co-insurance | Coverage is limited to 180 days. |
| If your child needs dental or eye care | Eye exam | Provider network is Vision Service Plan. The Plan provides covered exams and contracted eyewear in full. | Amount over \$35 | You pay for in-network upgrades. |
| | Glasses | | Amount over \$35 for frame and over \$30 for lenses | |
| | Dental check-up | No charge | No charge | -----none----- |

* The 20% in-network co-insurance only applies when Lineco is the person's primary plan. When Medicare is prime, the in-network co-insurance does not apply.

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.) | | |
|--|---|---|
| <ul style="list-style-type: none"> Cosmetic surgery | <ul style="list-style-type: none"> Habilitation services, except for speech therapy for children for treatment of congenital medical defects and acute diseases, including hearing deficits caused by specifically diagnosed illnesses, cerebral palsy, and neurological disorders | <ul style="list-style-type: none"> Infertility treatment |
| <ul style="list-style-type: none"> Long-term care | <ul style="list-style-type: none"> Private-duty nursing | <ul style="list-style-type: none"> Routine foot care |
| <ul style="list-style-type: none"> Weight loss programs | | |

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Line Construction Benefit Fund: Medicare-Secondary

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Family Plan Type: PPO

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 pre-certified (only one per lifetime and not covered for children)
- Chiropractic care, subject up to \$600 annual maximum for all spinal manipulations/adjustments (and related services)
- Dental care (Adult)
- Hearing aids up to \$2,500 every 5 years (every 2 years for children)
- Non-emergency care when traveling outside the U.S.
- 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 1-800-323-7268. 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 Appeal 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 1-800-323-7268. 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 1-800-323-7268.

Tagalog (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-800-323-7268.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-323-7268.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-323-7268.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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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 \$5,960
- Patient pays \$1,580

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 | \$300 |
| Co-pays | |
| Co-insurance | \$1,130 |
| Limits or exclusions | \$150 |
| Total | \$1,580 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,030
- Patient pays \$1,370

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 | \$300 |
| Co-pays | |
| Co-insurance | \$990 |
| Limits or exclusions | \$80 |
| Total | \$1,370 |

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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.

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