COUNTY OF KANE

Corinne M. Pierog MA, MBA
Kane County Board Chairman

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DOCUMENT VET SHEET

For
Corinne Pierog
Chairman, Kane County Board

Name of Document: KCSO Court Security Sergeants CBA Resolution No.: 23-115

01/01/2023 through 12/31/2025

Submitted by: Dawn Troost

Date Submitted: 3/16/2023

Dept. Head Signature & Date: _____
(Subject Matter Sign-off)

Legal Review of Contract Terms (Atty. Sign-off): Dawn Troost

Approved by: (Legality)
Dawn Troost
(Print Name)
Dawn Troost
(Signature)
03/15/2023
(Date)

Post on Web: Yes X No _____ Atty. Initials DT

Comments: _____

Chairman signed: Yes ✓ No _____ Date 3/17/23

Document returned to: Dawn Troost
(Name/Department)

AGREEMENT BETWEEN
THE SHERIFF OF KANE COUNTY AND THE
COUNTY OF KANE
AND
GENERAL CHAUFFEURS, SALESDRIVERS, AND
HELPERS, LOCAL UNION NO. 330
FOR
COURT SECURITY SERGEANTS

EFFECTIVE JANUARY 1, 2023 THROUGH DECEMBER 31, 2025

TEAMSTERS LOCAL 330 EXECUTIVE BOARD
2400 BIG TIMBER RD., BLDG. B, SUITE 201
ELGIN, IL 60124
(847-695-1516)

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Website: www.teamsters330.org

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PREAMBLE

This Agreement is entered into by the Sheriff of Kane County ("Sheriff") and County of Kane ("County"), hereinafter referred to as the "Sheriff", "County" or "Employer", and the International Brotherhood of Teamsters Local 330, hereinafter referred to as the "Union".

In consideration of mutual promises, covenants and Agreement contained herein, the parties hereto, by their duly authorized representative and/or agents, do mutually covenant and agree as follows:

ARTICLE 1
RECOGNITION

Section 1. Unit Description

The Employer hereby recognizes the Union as the sole and exclusive collective bargaining representative for the purpose of collective bargaining on matters relating to wages, hours, working conditions and other terms and conditions of employment for the following unit:

> All full-time Court Security Sergeants. Excluded: Director of Court Security, Court Security Lieutenant and all other supervisory, managerial, and confidential employees and all other employees excluded by the Illinois Public Employees Labor Relations Act and all employees within any other collective bargaining agreement.

Section 2. New Classifications

If a new position classification is created by the Employer, the Employer shall set the proper pay grade for the classification.

The Employer shall determine the proposed salary grade in relationship to:

1. The job content and responsibilities attached thereto in comparison with the job content and responsibilities of other position classifications in the Employer's work force;

2. Like positions with similar job content and responsibilities within the Kane County Government System if available otherwise to the Kane County Labor Market generally;

3. Significant differences in working conditions to comparable position classifications.

If the Union does not agree with the determination of the proposed salary grade the Employer establishes under this paragraph, then the Union shall within ten (10) days request a meeting with the Employer to discuss the Employer's action. The Employer shall thereafter meet with the Union and render a decision within twenty (20) calendar days. If the Union still disagrees with the decision of the Employer, they may submit the matter to Step 4 of the Grievance Procedure within ten (10) days from receipt of the Employer's decision.

Section 3. Non-Bargaining Unit Personnel

Non-Bargaining Unit Personnel may continue to perform bargaining unit work which is incidental to their jobs. However, they may perform bargaining unit work in emergency situations and where such work is necessary to train a bargaining unit employee. Such work by said personnel shall not cause any layoffs of the bargaining unit

employees. Nothing in this paragraph is intended to alter or reduce the Employer's Management Rights.

Section 4. Student Interns

The Sheriff may continue to utilize the services of student interns to assist and observe bargaining unit work in accordance with past practice and the Illinois Public Labor Relations Act.

Section 5. Abolition, Merger or Change of Job Classification

If the Employer determines to abolish, merge or change existing classifications, the Employer shall negotiate with the Union over the impact of such. Such negotiations shall include good faith impact bargaining as required under the Illinois Public Labor Relations Act. The Parties agree that a change in job title in the bargaining unit shall not remove the job position from the bargaining unit as long as the type of work performed by the position remains essentially the same.

Section 6. Job Audit/Reclassification

Any employee who believes that he/she is performing work outside his/her job description shall be granted a job audit on the work being performed. A written request for a job audit or reclassification will be submitted through the Union and a written decision returned by management within sixty (60) days. If the job audit creates a reclassification for that employee, the affected employee(s) shall receive any retroactive increase in pay that was created by the reclassification.

ARTICLE 2
PROBATIONARY EMPLOYEES

Employees shall be "probationary employees" for his/her first twelve (12) months of employment with the Sheriff's Office. No matter concerning the discipline, layoff, transfer or termination of a probationary employee shall be subject to the grievance and arbitration procedures. A probationary employee shall have no seniority except as otherwise provided in this Agreement, until he/she has completed his/her probationary period. Upon completion of his/her probationary period, he/she will acquire seniority from his/her date of hire.

ARTICLE 3
SAVINGS CLAUSE

If any provision of this Agreement or any application thereof should be rendered or declared unlawful, invalid, or unenforceable by virtue of any judicial action, the remaining provisions of this Agreement shall remain in full force and effect. In such event, upon the request of either party, the parties shall meet promptly and negotiate with respect to substitute provisions for those provisions rendered or declared unlawful, invalid, or unenforceable.

ARTICLE 4
UNION SECURITY

Section 1. Maintenance of Membership

Check Off: When a new employee is hired, the Employer shall make a legitimate effort to notify the Union's designated Business Agent and the Union office on, or before, the first (1st) day of employment. Such notice shall contain the employee's name, address, phone number, position title and rate of pay. The Union will be given the opportunity to meet with the new employee on their first (1st) day of employment, subject to operational needs, so that the Union may present him/her with membership materials including a dues check off card. Where laws require written authorization by the employee, same is to be furnished on the required form. No deductions shall be made which are prohibited by applicable law. Upon receipt of a voluntarily signed written dues check off authorization from an employee covered by this Agreement, the Employer shall deduct the uniform Union dues of such employee from his/her regular pay and remit such deductions to the Union office. The Parties agree to the extent the rights contained within this Section exceed the requirements contained within the Illinois Public Labor Relations Act (the "Act"), but are not pre-empted or barred by the Act, the provisions of this Section will control. Nothing in this collective bargaining agreement shall be construed as a waiver of the Employers', employees' or the Union's rights under applicable law.

Section 2. Notice and Appeal

The Union agrees to provide notices and appeal procedures to employees in accordance with the applicable law.

Section 3. Indemnification

The Union shall indemnify, defend, and hold the Employer harmless against any claim, demand, suit or liability arising from any action taken by the Employer in complying with this Article.

ARTICLE 5
NON-DISCRIMINATION

Section 1. Prohibition against Discrimination

Both the Employer and the Union agree not to illegally discriminate against any employee on the basis of race, sex, creed, religion, color, marital or parental status, age, national origin, political affiliation, disability, or veteran status; provided, however, that all personnel of the Sheriff must at all times support and defend the Constitution and laws of the United States, State of Illinois and laws promulgated therefrom.

Section 2. Union Membership or Activity

Neither the Employer nor the Union shall interfere with the right of employees covered by this Agreement to become or not become members of the Union, and there shall

be no discrimination against any such employees because of lawful Union membership or non-membership activity or status.

Section 3. Equal Employment/Affirmative Action

The parties recognize the Employer's obligation to comply with federal and state Equal Employment and sex discrimination laws applicable to the Sheriff.

ARTICLE 6
NO STRIKE OR LOCKOUT

Section 1. No Strike Commitment

Neither the Union nor any bargaining unit employee will call, initiate, authorize, participate in, sanction, encourage, or ratify any work stoppage, slowdown, or the concerted interference with the full, faithful, and proper performance of the duties of employment with the Sheriff during the term of this Agreement. No bargaining unit employee shall refuse to cross any picket line, by whomever established.

Section 2. Performance of Duty

It is recognized that employees covered by this Agreement may be required in the line of duty to perform duties growing out of or connected with labor disputes which may arise within the County. The Union agrees that no disciplinary action or other action will be taken by the Union against any employee or employees covered by this Agreement by reason of any such action or conduct in the line of duty.

Section 3. Resumption of Operations

In the event of action prohibited by Section 1 above, the Union immediately shall disavow such action and request the employees to return to work and shall use its best efforts to achieve a prompt resumption of normal operations. The Union, including its officials and agents, shall not be liable for any damages, direct or indirect, upon complying with the requirements of this Section.

Section 4. No Lockout

No lockout of employees shall be instituted by the Employer during the term of this Agreement.

ARTICLE 7
SENIORITY

Section 1. Definition

For the purpose of this Agreement the following definitions shall apply:

1. County-wide Seniority means an employee's uninterrupted employment with the County since their last date of hire as listed in Appendix A.

2. Classification Seniority means the length of uninterrupted employment an employee has in their current classification. Where employees have the same classification seniority date, any such tie shall be broken at the time of hire or promotion by drawing lots.

3. Office Seniority means the length of uninterrupted employment an employee has in the Sheriff's Office.

Section 2. Loss of Seniority

An employee shall lose his/her applicable seniority in accordance with Section 1 and no longer be an employee if:

1. He/she resigns or quits by giving an official letter of resignation.

2. He/she is discharged for just cause unless reversed through the Grievance or Arbitration Procedure or the Merit Commission, whichever is applicable.

3. He/she retires.

4. He/she does not return to work from layoff or authorized leave of absence within ten (10) calendar days after being notified by certified mail to return.

5. He/she has been on layoff for a period of time equal to his/her seniority at the time of his/her layoff or two (2) years, whichever is greater.

6. Accepts "gainful employment" that is inconsistent with the purpose of the authorized leave while on an approved leave of absence from the Sheriff's Office.

Section 3. Classification Seniority List

The Sheriff and Union have agreed upon the initial classification seniority list setting forth the present seniority dates for all employees covered by this Agreement and shall become effective on or after the date of execution of this Agreement. Such lists shall resolve all questions of seniority affecting employees covered under this Agreement or employed at the time the Agreement becomes effective. Disputes as to seniority listing shall be resolved through the grievance procedure. The initial agreement is attached hereto as Appendix A and made a part thereof.

Section 4. Seniority While on Leave

Employees will not continue to accrue seniority credit for all time spent on authorized unpaid leave of absence beyond three (3) months except for authorized leave due to circumstances beyond the control of the employee such as medical leave, military leave, etc.

ARTICLE 8
LAYOFF AND RECALL

Section 1. Procedure for Layoff

1. When employees are removed from a classification for the purpose of reducing the work force of that classification, the employee with the least seniority in the affected classification and bargaining unit shall be removed first.

2. A removed employee shall be transferred, conditioned upon being qualified to perform the work available in the following order or priority:

   a. To a vacancy, if any, in another classification in the same pay grade within the same bargaining unit;

   b. To replace an employee with less seniority, if any, in another classification in the same pay grade within the same bargaining unit;

   c. To a vacancy, if any, in a classification assigned to the next lower pay grade with the same bargaining unit;

   d. To replace an employee with less seniority, if any, in a classification assigned to the next lower pay grade within the same bargaining unit.

3. A removed employee not transferred as provided in 2 above shall have the procedure set forth in 2c above applied to classifications assigned to each succeeding next lower pay grade until he/she is transferred or laid off.

4. The procedure set forth in 2 and 3 above shall be applied for an employee who is replaced as a result of the application of the above procedure until he/she is transferred or laid off.

5. In applying the procedures set forth 2, 3, and 4 above, a removed or replaced full-time employee shall be transferred to another full-time position.

6. In applying the above procedures, full-time probationary employees shall be removed from the affected classification or replaced, as the case may be, prior to removing or replacing full-time, non-probationary employees.

7. Temporary employees shall be laid off prior to the layoff of any full-time employees.

Section 2. Procedure for Recall

An employee with seniority who has been laid off or transferred as a result of a layoff shall be recalled to work, conditioned upon ability to perform the work available, in accordance with the reverse application of the procedure for layoff. Recall rights shall

continue for two (2) years after an employee has been laid off. No new employees at all shall be hired until all employees on layoff desiring to return to work shall have been given the opportunity to return to work.

In the event of recall, eligible employees shall receive notice of recall either by actual notice or by certified mail, return receipt requested. It is the responsibility of all employees eligible for recall to notify the Sheriff of their current address. Upon receipt of the notice of recall, employees shall have five (5) working days to notify the Sheriff of their acceptance of the recall. The employee shall have five (5) working days thereafter to report to duty.

Section 3. Notice

The Employer shall notify the Union thirty (30) days prior to the intended effective date of a planned layoff. The Employer and the Union will discuss alternatives to the layoff if put forth by the Union.

Any employee to be laid off will be notified thirty (30) calendar days prior to the effective date.

ARTICLE 9
GRIEVANCE PROCEDURE

Section 1. Grievance

A Grievance is defined as a dispute or disagreement as to the interpretation and application of any provision in this Agreement. Grievances may be processed by the Union on behalf of an employee or on behalf of a group of employees or itself setting forth name(s) or group(s) of the employee(s). Either party may have the grievant or one (1) grievant representing a group grievance present at any step of the grievance procedure. The resolution of a grievance filed on behalf of a group of employees shall be made applicable to the appropriate employees within that group. Nothing in this Article is designed to alter a superior officer's duties in the chain of command.

Business days shall include the weekdays of Monday through Friday, excluding holidays or other days the Sheriff's Office administrative functions are closed.

Section 2. Grievance Steps

Step 1. Lieutenant of Court Security

The Employee and/or the Union shall orally raise the grievance with the Lieutenant of Court Security. The employee shall inform the Lieutenant of Court Security that this discussion constitutes the first step of the grievance procedure. All grievances must be presented not later than ten (10) business days from the date the grievant became aware of the occurrence giving rise to the complaint. The Lieutenant of Court Security shall render an oral response to the grievance within ten (10) business days after the grievance is presented. If the oral grievance is not resolved at Step 1, the Lieutenant of Court Security shall sign the written statement of grievance prepared for submission at Step 2

acknowledging discussion of the grievance. In those circumstances where securing the signature of the Lieutenant of Court Security who is physically not available to sign would have adversely affected a timely submittal to the second level, the grievance will be submitted to the second level without such signature. A copy of the grievance shall subsequently be provided to the Lieutenant of Court Security for such signature. The parties recognize that variations from the Lieutenant of Court Security, where mutually agreeable, may exist. The Union is entitled to be present at any grievance meeting and any grievance settlement should not conflict with this Agreement.

Step 2. Chief Deputy/Undersheriff

In the event the grievance is not resolved in Step 1, it shall be presented in writing by the Union to the Chief Deputy/Undersheriff or his/her designee within five (5) business days from the receipt of the answer, or the date such answer was due, whichever is earliest. Within five (5) business days after the grievance is presented to Step 2, the Chief Deputy/Undersheriff shall render a written answer to the grievant and provide a copy of such answer to the Union. The written grievance shall be on an agreed upon form. The written grievance shall contain a statement of the grievant's and/or Union's complaint, the section(s) of the Agreement allegedly violated, if applicable; the date of the alleged violation, if applicable, and the relief sought. The grievance form will be the standard Teamsters Local 330 form (a copy of which is attached hereto as Appendix F) and shall be signed and dated by the grievant or Union. An improper grievance form, date, or section citation shall not be grounds for denial of the grievance.

Step 3. Sheriff

If the grievance is still unresolved, it shall be presented by the Union to the Sheriff or his/her designee in writing within five (5) business days after receipt of the Step 2 response or after the Step 2 response is due, whichever is earliest, or within five (5) business days after the Step 1 response, or after Step 1 response is due, if Step 2 is not applicable.

Within five (5) business days after receipt of the written grievance the parties shall meet or hold other discussions in an attempt to solve the grievance unless the parties mutually agree otherwise. The Sheriff or designee shall give his/her written response within five (5) business days following the meeting.

Step 4. Arbitration

If the grievance is still unsettled, and the Union wishes to proceed to arbitration, the grievance must be presented to arbitration within fifteen (15) business days after the receipt of the Step 3 response or the date the response was due, whichever is earlier. The Union shall notify the Sheriff in writing of the intent to proceed to arbitration.

Upon written request of either party, the Sheriff and the Union, with mutual consent, may meet within ten (10) business days after receipt of the Step 3 response or the date the response was due for the purpose of conducting a pre-arbitration conference in a final attempt to resolve the grievance without proceeding to arbitration.

If no resolution is reached and arbitration is requested, representatives of the Sheriff and the Union shall meet to select an arbitrator. If the parties are unable to agree on an arbitrator within five (5) business days, the parties shall request the Federal Mediation and Conciliation Service to submit a list of seven (7) arbitrators. The parties shall alternately strike the names of three (3) arbitrators. The Sheriff shall be the first to strike, and the Union will follow. The person whose name remains shall be the arbitrator, provided that either party, before striking any names, shall have the right to reject one (1) panel of arbitrators. The arbitrator shall be notified of his/her selection by a joint letter from the Sheriff and the Union, requesting that he/she set a time and place for the hearing, subject to the availability of the Sheriff and Union representatives and shall be notified of the issue where mutually agreed by the parties.

The Employer or Union shall have the right to request the arbitrator to require the presence of witnesses and/or documents. Each party shall bear the expense of its own witnesses who are not employees of the Employer.

The arbitrator shall neither amend, modify, nullify, ignore, add nor subtract from the provisions of the Agreement.

The expenses and fees of the arbitrator and the cost of the hearing room shall be shared equally by the parties. Nothing in this Article shall preclude the parties from agreeing to use expedited arbitration procedures.

The decision and award of the arbitrator shall be final and binding on the Employer, the Union, and the employee or employees involved.

If either party desires a verbatim record of the proceeding, it may cause such a record to be made, providing it pays for the record and makes a copy available without charge to the arbitrator. If the other party desires a copy it shall pay for one half (1/2) the transcription fee and the cost of duplicating its copy.

Section 3. Time Limits

1. Grievances may be withdrawn at any step of the Grievance Procedure. Such withdrawal shall not constitute a decision on the merits of the Grievance. Grievances not raised or appealed within the designated time limits will be barred.

2. The time limits at any step or for any hearing may be extended by mutual agreement of the parties involved at that particular step.

3. Failure to respond within the time limits by the designated person shall automatically advance the grievance to the next step.

Section 4. Time Off, Meeting Space and Telephone Use

1. Time Off: The grievant(s) and/or Union grievance representative will be permitted reasonable time without loss of pay during their work hours to investigate and process grievances. A grievant who is called back on a

different shift or on his/her day off as a result of the Sheriff scheduling a grievance meeting shall have such time spent in the meeting considered as time worked. Witnesses whose testimony is pertinent to the Union's presentation or argument will be permitted reasonable time without loss of pay to attend grievance meetings and/or respond to the Union's investigation. No employee or Union representative shall leave his/her work to investigate, file or process grievances without first notifying and receiving permission from his/her supervisor or designee as well as the supervisor of any unit to be visited, and such permission shall not be denied unreasonably. Employees attending grievance meeting shall normally be those having direct involvement in the grievance.

2. Meeting Space and Telephone Use: Upon request, the employee and Union representative shall be allowed the use of an available appropriate room while investigating or processing a grievance; and, upon prior general approval, shall be permitted the reasonable use of telephone facilities for the purpose of investigating or processing grievances. Such use shall not include any long distance or toll calls at the expense of the Employer.

Section 5. Advanced Grievance Step Filing

Certain issues which by nature are not capable of being settled at a preliminary step of the grievance procedure or which would become moot due to the length of time necessary to exhaust the grievance steps, may by mutual agreement be filed at the appropriate advance step where the action giving rise to the grievance was initiated. Mutual agreement shall take place between the appropriate Union representative and the appropriate Employer representative at the step where it is desired to initiate the grievance.

Section 6. Pertinent Witnesses and Information

Either Party may request the production of specific documents, books, papers or witnesses reasonably available from the other party and substantially pertinent to the grievance under consideration. Such request shall not be unreasonably denied, and shall be in conformance with applicable laws, and rules issued pursuant thereto, governing the dissemination of such materials. This paragraph is not applicable to Step 1 of the grievance procedure. Requests made pursuant to this section by the Union may only be initiated by a Union Representative or his designee.

ARTICLE 10
DISCIPLINE AND DISCHARGE

Section 1. Discipline and Discharge

The parties recognize the principles of progressive and corrective discipline.

Disciplinary action or measures shall include the following:

1. Oral Reprimand

2. Written Reprimand

3. Suspension (notice to be given in writing)

4. Discharge (notice to be given in writing)

Disciplinary action may be imposed upon an employee only for just cause.

If the Sheriff has reason to reprimand an employee, it shall be done in a discrete manner that will not embarrass the employee before other employees or the public.

Employees must sign for receipt of oral and written reprimands, but the signature does not indicate that employees are in agreement with the discipline.

Oral or written reprimands shall be subject to the grievance procedure through Step 3 thereof but shall not be subject to arbitration.

Section 2. Limitation

The Sheriff's agreement to use progressive and corrective disciplinary action does not prohibit the Sheriff in any case from imposing discipline which is commensurate with the severity of the offense. The Sheriff shall notify both the employee and Union of disciplinary action. Such notification shall be in writing and shall reflect the specific nature of the offense.

Section 3. Pre-Disciplinary Meeting

For discipline other than oral and written reprimands, prior to imposing the contemplated discipline on the employee, the Sheriff or his/her designee shall meet with the employee involved and inform the employee of the contemplated discipline and the reason thereof. The employee shall be informed of his contract rights to Union representation and shall be entitled to such, if so requested by the employee, and the employee and Union representative shall be given the opportunity to rebut or clarify the reasons for such discipline and further provided that a Union representative shall be available within twenty-four (24) hours of notification or as mutually agreed by the parties.

Section 4. Investigative Interviews

Where the Sheriff or his designee desires to conduct an investigative interview of an employee where the results of the interview might result in discipline, the Sheriff agrees to first inform the employee that the employee has the right to Union representation at such interview. If the employee desires such Union representation, no interview shall take place without the presence of a Union representative. The role of the Union representative is limited to assisting the employee, clarifying the facts and suggesting other employees who may have knowledge of the facts.

Section 5. Removal of Discipline

Records of discipline other than suspensions shall be removed from the employee's personnel file if one (1) year passes from the date of the offense without the employee receiving discipline for the same offense.

Section 6. Merit Commission

Sheriff's Merit System Employees covered under this Agreement shall be disciplined pursuant to Section 3-8013 of the Sheriff's Merit System Law, 55 ILCS 5/3-8013 (2011) subject to the alternative grievance review provisions provided in this Agreement.

In the event charges are referred to the Merit Commission, the employee shall have the option of waiving a hearing before the Merit Commission and shall then be disciplined by the Sheriff subject to the contractual grievance appeal procedure. To effectuate this election, the following procedure shall be utilized:

1. Within ten (10) business days of the employee receiving a copy of the charges referred to the Merit Commission and the entire investigation file relating to the charges, the Union will advise the Sheriff and the Merit Commission of the employee's election under this Section to waive his or her right to a Merit Commission review and/or hearing and proceed, instead, in accordance with the grievance/arbitration provisions of Article 9 of this Agreement, upon the issuance of discipline by the Sheriff. Such notice shall be in writing and shall include a written waiver, executed by the employee, acknowledging that the employee is knowingly waiving his or her rights to a hearing before the Merit Commission. If no such notice/waiver is provided within the ten (10) business days, the employee and the Union shall be deemed to have elected to proceed under the rules of the Merit Commission and all rights under Article 9 shall be deemed waived.

2. Upon receipt of a notice from the Union that the employee is electing to proceed under the grievance/arbitration provisions of Article 9, the Sheriff's Office will withdraw the charges before the Merit Commission. Thereafter, the Sheriff or his designee will make a determination regarding discipline.

3. Once discipline is issued by the Sheriff or his designee, the employee, or the Union, as applicable, may grieve the discipline, as provided in Article 9 of the CBA commencing at Step 4. The filing of said grievance shall serve as a Request for Arbitration under Step 4 of the grievance procedure.

In the event the Sheriff's Merit System Law is amended in a manner which nullifies the rights of parties to a collective bargaining agreement to negotiate, pursuant to Section 3-8013 of the Sheriff's Merit System Law, an alternative disciplinary review process, or which makes the alternative grievance review provisions contained in this section illegal, either party may request to immediately re-negotiate the terms of this section. Such negotiations shall thereafter commence immediately.

Section 7. Suspension Day Defined

A suspension day is a twenty-four (24) hour period during which an employee was scheduled to work a regular tour of duty but has been ordered not to report for duty. If the suspension is administrative in nature, the employee will be paid for the time as if he or she had worked. If the suspension is disciplinary in nature, the employee will have his or her pay docked the appropriate amount.

Section 8. Limitation of the Suspension Period

During any suspension period, defined as the period between the first and final actual suspension days (inclusive), an employee may not work for paid overtime, providing the duration of the suspension period is not more than four (4) times the number of actual suspension days. The suspension period shall start not more than fifteen (15) days from the date of the pre-disciplinary hearing.

ARTICLE 11
PERSONNEL FILES

Section 1. Personnel Files

The Sheriff shall keep a central personnel file for each employee within the bargaining unit. The Sheriff is free to keep working files, but material not maintained in the central personnel file may not provide the basis for disciplinary or other action against an employee.

Section 2. Inspection

Upon request of an employee, the Sheriff shall reasonably permit an employee to inspect his personnel file subject to the following:

1. Such an inspection shall occur within two (2) business days following receipt of the request. The Sheriff or his designee may be present during such inspection;

2. Such inspection shall only occur during daytime office staff working hours Monday through Friday upon written request;

3. The employee shall not be permitted to remove any part of the personnel file from the premises but may obtain copies of any information contained therein;

4. Upon written authorization by the requesting employee, that employee may have a representative of the Union present during such inspection;

5. Pre-employment information, such as reference reports, credit checks or information provided to the Sheriff with a specific request that it remain confidential, shall not be subject to inspection or copying.

6. An employee may not place any type of document into the personnel files maintained by the Sheriff without permission, except pursuant to the Illinois Employee Personnel Record Review Act.

Section 3. Notification

Employees shall be given notice by the Sheriff when any materials are placed in their personnel file except those of a routine, clerical nature.

Section 4. Limitation on Use of File Material

It is agreed that any material not available for inspection, such as provided in Sections 1 and 2 above, shall not be used in any manner or any forum adverse to the employee's interest.

Section 5. Personnel Record Correction

If the employee disagrees with any information contained in the personnel record, a removal or correction of that information may be mutually agreed upon by the employee and Sheriff. The employee may submit a written statement explaining the employee's position, which shall be attached to the personnel record.

ARTICLE 12
EMPLOYEE DEVELOPMENT & TRAINING

Section 1. Orientation

The Sheriff and the Union recognize the need for the training and development of employees in order for services to be efficiently and effectively provided, and employees are afforded the opportunity to develop their skills and potential. In recognition of such principle, the Sheriff shall endeavor to provide employees with reasonable orientation with respect to current procedures, forms, methods, techniques, materials, and equipment normally used in such employees' work assignments and periodic changes therein, including, where available and relevant to such work, procedural manuals. Within their first (1st) year of hire or promotion, the Employer will utilize best efforts to provide employees with a minimum of forty (40) hours of supervisory training, unless circumstances arise that preclude the Sheriff from providing such training.

Section 2. Time Off

If, because of changes in certification, accreditation or licensure, employees are required by the Sheriff to take courses so as to retain their present position classification, such employees shall be granted reasonable time for such without loss of pay.

ARTICLE 13
HOLIDAYS

Section 1.

All employees shall receive holidays approved annually by the Chief Judge for court related offices of Kane County.

Section 2.

Permanent full-time employees shall receive a full day's pay for the scheduled holiday.

Section 3.

To qualify for holiday pay, an employee must be in paid status the day preceding and following the holiday.

Section 4.

When a scheduled holiday occurs during a scheduled vacation, an additional day of vacation will be allowed.

Section 5.

Except as otherwise set forth in this Article, employees shall not be scheduled or called in to work on holidays. In the event the Chief Judge orders the court to be open on a holiday and employees are called in to work, employees shall be paid at one and one-half (1 ½) times their regular rate of pay and receive an accumulated paid holiday off to be taken at a later date in accordance with classification seniority.

ARTICLE 14
VACATIONS

Section 1. Accrual

All employees shall earn paid vacation in accordance with the schedule below. Part time employees shall receive vacation time proportionate to the average hours worked. Employees shall accumulate vacation based on countywide seniority. Accrual and use of vacation time are based on the fiscal year, December 1 through November 30.

1. From hire date through the end of the fiscal year, vacation time is earned at a rate of .833 days per month (.833 x 12 = 10) to determine the number of vacation days accrued for the following fiscal year. Any fraction of accrued vacation days will be converted to the nearest whole day using standard mathematical rounding (.49 or lower to be rounded down and .50 and higher to be rounded up). At the start of the second fiscal year following an employee's start date to five years of service, the employee will receive a total of ten (10) vacation days during that fiscal year. Vacation time is

earned at a rate of .833 days per month (.833 x 12 = 10) to determine the number of vacation days accrued for the following fiscal year.

2. At the completion of four (4) years of service, vacation time is earned at a rate of 1.25 days per month (1.25 x 12 = 15). During the fiscal year in which the employee completes five (5) years of service, the employee will receive five (5) additional vacation days upon the anniversary of his/her hire date. At the start of the fiscal year immediately following the completion of five (5) years of service, the employee will receive a total of fifteen (15) vacation days for use in that fiscal year.

3. At the completion of nine (9) years of service, vacation time is earned at a rate of 1.66 days per month (1.66 x 12 = 20). During the fiscal year in which the employee completes ten (10) years of service, the employee will receive five (5) additional vacation days upon the anniversary of his/her hire date. At the start of the fiscal year immediately following the completion of ten (10) years of service, the employee will receive a total of twenty (20) vacation days for use in that fiscal year.

4. At the completion of twenty-four (24) years of service, vacation time is earned at a rate of 2.08 days per month (2.08 x 12 = 25). During the fiscal year in which the employee completes twenty-five (25) years of service, the employee will receive five (5) additional vacation days upon the anniversary of his/her hire date. At the start of the fiscal year immediately following the completion of twenty-five (25) years of service, the employee will receive a total of twenty-five (25) vacation days for use in that fiscal year.

Section 2. Use

Vacation time may be taken in increments of not less than one (1) hour at a time subject to accrual as outlined above. Vacation time must be used prior to November 30 of each year or it will be forfeited. In certain extraordinary circumstances, unused vacation time may be carried over if specifically authorized by the Employer. Vacation time that is carried over will be used based on the operational needs of the Office, and must be taken within sixty (60) days.

Employees who by length of continuous service are entitled to fifteen (15) or more days of vacation may request the following:

After accrual of fifteen (15) days of vacation, a maximum of five (5) days may be turned back in to be paid at straight time in lieu of time off. After accrual of twenty (20) days of vacation, a maximum of ten (10) days may be turned back in to be paid at straight time in lieu of time off. Employees who are selling back vacation time must indicate in writing their intent to do so by September 1 of the applicable fiscal year. Once made, such election is irrevocable, and the time will be paid out via direct deposit within two regular payroll periods following the election.

Section 3. Scheduling of Single Vacation Days, Personal/Sick Days and Compensatory Time Off

Provided the maximum number of employees permitted to be off on a single day, as described herein, has not been reached, an employee will be granted a single vacation day, personal/sick day or compensatory time off on a first come, first serve basis. Unless otherwise approved by the Court Security Lieutenant or another supervisor higher in the chain of command, no more than one (1) Employee will be granted confirmed time off (including vacations, single vacation days, personal/sick days, and compensatory time, but excluding FMLA and extended sick leave) for a specific day.

Section 4. Vacation Periods Scheduled by Seniority

A vacation period will be considered in increments of one (1) or more full week(s) beginning at 0001 Sunday and ending at 2359 Saturday.

After completion of the shift bid process, the supervisor who is outside the bargaining unit will tally the total number of weeks of vacation due the employees on a shift.

Beginning October 1 and continuing for one (1) month, employees may bid for vacation periods (one (1) or more weeks) based on classification seniority. This will be done by filling in slots on a posted list of weeks in the following fiscal year (i.e., December 1 – November 30). Bids shall be submitted by employees in a timely manner, with employees receiving up to twenty-four (24) hours to complete their bids. On or about the first week in November, the Lieutenant of Court Security will review the posted list and finalize the seniority bid vacation lists. Conflicts in scheduling will be resolved in favor of the employee having the greatest classification seniority.

Vacation periods requested other than as described above shall be granted on a first-come first-served basis. Requests will be considered on the basis of calendar date of submission to and confirmed by the Lieutenant of Court Security. Employees will be notified in writing as to the number of available vacation slots via posting of the vacation list and will be notified of the number of uncommitted vacation weeks still held by the employee via email. It will be up to the employee to submit a request for any of the remaining available weeks or face the loss of vacation time when no open weeks remain in the fiscal year.

If an employee decides to remove his or her name from a scheduled vacation week or weeks, another employee may bid for the open slot and be granted the time based on classification seniority.

Once a vacation is approved and scheduled, an employee who is transferred non-voluntarily will be allowed to take that vacation even if a scheduling conflict develops.

Section 5. Holidays

When a scheduled holiday occurs during a scheduled vacation, an alternate day of vacation will be allowed.

Section 6. Separation Pay

Employees, or his/her estate in case of death, shall be compensated for all unused vacation time already accrued at the time they separate.

ARTICLE 15
SICK LEAVE POLICY

Section 1.

It is the policy of Kane County to provide protection for eligible employees against loss of income because of illness. To ensure that protection, the County has made provisions for both short-term and extended sick leave reserves. All regular full-time and regular part-time employees are eligible. Sick leave pay is based on the employee's regular straight-time rate in effect when the sick leave is taken. An employee may use extended sick leave whenever under the care of a physician.

Section 2. Short-Term Sick Leave/Personal Day Accumulation

"Sick leave year" is defined as the twelve (12) month period beginning December 1 of each year. Eligible employees who have completed twelve (12) months of continuous service as of December 1, of the applicable sick leave year, will be credited with five (5) days. Employees who have completed less than twelve (12) months of continuous service as of December 1 of the applicable sick leave year, will be credited with short-term sick leave at the rate of one and a quarter (1.25) day for each remaining quarter within that year once they have completed six (6) months of employment with the Sheriff's Office.

Section 3. Short-Term Sick Leave/Personal Day Utilization

An employee's short-term sick leave credit can be used for personal and family injury or illness, maternity, doctor and dentist appointments or personal days. Such leave may be used in increments of no less than one (1) hour at a time. Any such use is subject to twenty-four (24) hours prior notification to the employee's supervising Court Security Lieutenant or his/her designee, if at all possible. Vacation pay cannot be substituted for short-term sick pay.

Section 4. Unused Short-Term Sick Leave/Carry Over and Payment at Termination

Short-term sick leave will not accumulate from year to year. At the end of the sick leave year, all unused short-term sick leave for nonexempt employees will roll over into extended sick leave. Upon termination, nonexempt employees will be expected to pay back any and all short-term sick days used that were not previously earned, at a rate of one and a quarter (1.25) day(s) for every quarter not worked. If a nonexempt employee terminates and has unused short-term sick leave, the employee will be paid at a rate of one and a quarter (1.25) day(s) for every quarter worked in the benefit year provided the employee gives fourteen (14) calendar days' written notice to the employee's designated supervisor.

Section 5. Extended Sick Leave Accumulation

Eligible employees will be credited with one (1) day of extended sick leave per month after six (6) months of continuous employment. Unused extended sick leave will carry over from year to year and may accumulate to a maximum of two hundred forty (240) days.

Section 6. Extended Sick Leave Utilization

An employee may utilize extended sick leave for himself/herself prior to utilizing short-term sick leave if the employee has a serious health condition and is under a doctor's care at home or in the hospital. A doctor's certification and/or note, as applicable, is required to support the request for extended sick leave.

Extended sick leave may be used during periods of personal injury, illness or maternity until IMRF disability benefits begin. The IMRF disability benefit is payable after thirty (30) calendar days of disability and is equal to fifty percent (50%) of the employee's average monthly earnings during the preceding twelve (12) months.

An employee may utilize up to six (6) days of accrued extended sick leave per fiscal year for absences due to illness or injury of the employee's child, stepchild, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent or stepparent on the same terms upon which the employee is able to use extended sick leave days for his or her own absences. A doctor's certification is required to support the request to use extended sick leave to care for such family members.

Extended sick days run concurrently with Family and Medical Leave.

Section 7. Payment for Unused Extended Sick Leave

No payment for unused extended sick leave is made at termination. Retiring employees under IMRF qualify for up to one year of additional pension service for unused extended sick leave at the rate of one (1) month for every twenty (20) days or fraction thereof. To qualify for this pension credit, the effective date of pension must be within sixty (60) days of termination. This additional pension service credit provision applies solely to employees retiring with an IMRF pension. Converted extended sick leave cannot be used to meet the requirements of a minimum of eight (8) years for an IMRF pension or thirty-five (35) years for a non-discounted pension under age sixty (60).

ARTICLE 16
MISCELLANEOUS PROVISIONS

Section 1. Use of Masculine Pronoun

The use of the masculine pronoun in this or any other document is understood to be for clerical convenience only, and it further understood that the masculine pronoun includes the feminine pronoun as well.

Section 2. Definition

Whenever the term Sheriff is used in this Agreement, it shall mean the Sheriff or his authorized officer or agent.

Section 3. Notification of Leave Balance

Employees shall be given a statement of leave balances (sick leave, vacation days, holidays, and accumulated compensatory time) on request, but no more than twice annually.

Section 4. Evaluations

The Union and the Sheriff encourage periodic evaluation conferences between the employee and his/her supervisor. The written evaluation done once a year by the supervisor shall be discussed with the employee and the employee shall be given a copy immediately after completion. The employee shall sign the evaluation as recognition of having read it but such signature shall not constitute agreement with the evaluation.

Section 5. Copies of the Agreement

A copy of this Agreement shall be posted to the Sheriff's Office's internal intranet site.

Section 6. Meeting Place

All meetings or hearings or other proceedings over which the parties have control shall be held in the Sheriff's complex in Kane County, Illinois, unless there is a reasonable basis to hold such meetings, hearings or other proceedings elsewhere.

Section 7. Job Descriptions

Within ninety (90) days of the execution of this Agreement, employees shall have a copy of his/her current job description which shall include principle duties and responsibilities. When requirements are revised and the duties and responsibilities remain essentially unchanged, incumbents in these positions who qualified under previous requirements for the class shall be considered qualified.

ARTICLE 17
LEAVES OF ABSENCE

Section 1. Policy

Leaves of absence may be granted to maintain continuity of service and to protect the employer-employee relationship in instances where circumstances require an employee's absence. Leaves of absence are required when the employee's absence, other than vacation, will extend beyond a two (2) week period. Leaves are granted based on each individual case and at the discretion of the Sheriff. Leaves of absence are without pay unless the Sheriff requires, or the employee elects with the Sheriff's approval, accrued sick

pay, holiday pay, vacation pay, or compensatory time be used during the leave of absence. A leave of absence will not be granted for the purpose of trying another job. Failure to return at the end of an approved leave may result in termination.

It is the Sheriff's policy to grant leaves of absence to eligible employees in accordance with all applicable federal and state laws. Where provisions of this Article conflict with any applicable federal or state law, the provisions of such law shall prevail.

Section 2. Eligibility

Employees may be eligible for a leave of absence if they have worked for at least twelve (12) months and for at least one thousand two hundred fifty (1,250) hours during the year preceding the start of the leave of absence. Eligibility and entitlement to leaves of absences governed by state or federal law shall be determined in accordance with the provisions of the applicable law.

Subject to the policy statement above, employees may be eligible for up to twelve (12) work weeks of leave a year, which is based on a rolling twelve (12) month period measured backward from the first date leave is used, unless otherwise required by law. In other words, each time an employee takes a leave, the remaining leave for which the employee may be eligible would be any balance of the twelve (12) work weeks which has not been used during the immediately preceding twelve (12) months.

Employees must give a thirty (30) calendar day advance notice of the need to take a leave of absence when it is foreseeable. Foreseeable leaves include, but are not limited to, maternity/paternity leave, placement leave, military leave, educational leave, personal leave or planned medical treatment leave. Where it is not possible under the circumstances to provide advance notice, notice must be given as soon as possible.

Section 3. Types of Leaves of Absence

1. Family and Medical Leave:

Eligible employees may be granted a family or medical leave of absence under the provisions of the Family and Medical Leave Act ("FMLA") for one (1) or more of the following reasons:

a. Birth Leave: For birth of a child of an employee and to provide care for the child following birth.

b. Placement Leave: For placement of the child with an employee for adoption or foster care.

c. Personal Illness: For a serious health condition when an employee is unable to perform their job.

d. Family Illness: For an employee to care for their son, daughter, spouse, or parent who has a serious health condition.

e. Because of any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is a covered military member on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

f. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the service member.

All aspects of FMLA leaves of absences shall be governed by the provisions of the FMLA and the regulations promulgated thereunder, all as may be amended from time to time. The Sheriff will exercise his discretion in connection with FMLA leaves of absences in accordance with the FMLA and the applicable regulations.

2. Military Leave: Eligible employees will be granted military leaves with or without pay in accordance with all applicable state and federal laws. For all Military Leaves, employees should provide their supervisor with a copy of their written orders, including any subsequent changes, within the time limits prescribed by law. If an employee is applying for differential pay, the employee should provide payroll with the amount of their base pay prior to the leave. If an employee desires to use benefit time during the leave, the employee should also notify payroll prior to the leave. Upon completion of military service, a copy of the employee's Leave and Earnings Statement verifying the duration of the employee's military service and base pay must be provided to payroll by the employee.

3. Victim's Economic Security and Safety Act (VESSA) Leave – Eligible employees will be granted leaves to address domestic or sexual violence in compliance with VESSA. Neither this section nor VESSA creates additional rights for an employee to take leave that exceeds the unpaid leave time under, or is in addition to unpaid leave time permitted by, the FMLA. All aspects of the leave shall be governed by the provisions of VESSA.

4. Personal Leave: May be granted or denied at the discretion of the Sheriff based on the facts of each individual case. The reason for this type of leave must be of a nature involving a serious family problem, or some similar circumstance. Personal leaves are governed in the same manner as any other type of leave. The guidelines listed under other Sections of this policy must be adhered to in all cases.

5. Educational Leave: May be granted at the discretion of the Sheriff without pay to eligible employees who wish to continue their education provided the course of study is beneficial to the Sheriff's Office.

6. Workers' Compensation Leave: All employees experiencing an occupational disability due to an accident or illness arising out of and in the course of their employment may be placed on a Workers' Compensation

Leave. Participating employees should apply for IMRF Disability Benefits if eligible (See Workers' Compensation).

7. Other Leaves Required by Law: Eligible employees will be granted leaves of absences required by state or federal law in accordance with the provisions of the applicable law.

Section 4. Controls and Rules During a Leave

1. The Sheriff may require that an employee requesting any type of leave designate that accrued sick days, accrued vacation and, if applicable, personal days and compensatory time be used during the leave of absence.

2. Duration of Leave: The cumulative time off of a leave of absence shall not be longer than six (6) months, unless otherwise required by law.

3. Extended Leave of Absence: Any leave over twelve (12) work weeks in duration is considered an extended leave of absence. Employees in this extended period must contact the Sheriff at least thirty (30) calendar days prior to their expected return to work, unless otherwise required by law. Every effort will be made to place the employee returning from an extended leave to the same or substantially similar position.

4. Health Care Coverage during a Leave of Absence: Group hospitalization coverage will continue for up to six (6) months. The employee portion of the payment for this coverage must be received in the Human Resource Management Department no later than the 1st of each month during the leave of absence. A limited continuation option is available to eligible employees after this period under COBRA, a limited extension of health insurance coverage.

5. Vacation. Sick Pay Benefits and Holiday Pay: Sick pay credit and vacation time will not continue to accrue after the last day paid on any authorized leave of absence. Employees will be paid for holidays which fall during the period they are receiving pay from the County. The use of any leave will not result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Section 5. Procedure

1. A "Request for Leave of Absence" form should be completed by the employee defining the reason for the leave, its duration, and the amount of vacation, compensatory time, holiday and sick pay to be used during the leave (if any).

2. This request should be submitted through the chain of command.

3. A medical certification and/or fitness for duty report is required upon commencing and returning from a family and medical leave or workers'

compensation leave. Employees must provide medical certification within fifteen (15) calendar days of the request. Medical re-certification may be required at the County's expense.

Section 6. IMRF Leave of Absence Authorization and Disability Benefits

1. Employees who have a medical certification of a disability which may extend for thirty (30) calendar days or more could be eligible for disability benefits under the Illinois Municipal Retirement Fund (see IMRF Disability Benefits). To be eligible, an employee must have twelve (12) months or more of service credit with IMRF. Pregnancy is included as a disability under IMRF if the employee is eligible, and claims should be submitted in the same manner as other disability claims. The County's Human Resource Management Department should be contacted for the forms for application.

2. Employees participating under IMRF and on a leave of absence without pay from Kane County or disability pay under IMRF (i.e., family illness, placement leave) will not be protected for death or disability benefits during the unpaid period. A Benefit Protection Leave of Absence Authorization should be filed with IMRF before the leave commences. Death and disability benefits are reinstated immediately upon returning to work. Employees may establish service credits for retirement (not to exceed twelve (12) months) for this leave by paying the employee contributions which would have been paid if actually working plus interest. The County Board must approve the acceptance of employer paid IMRF obligations. Forms are available in the Human Resource Management Department. Leaves of absence may be granted to maintain continuity of service and to protect the employer-employee relationship in instances where unusual circumstances require an employee's absence. Leaves are granted on the assumption that the employee will be available to return to regular employment when the conditions necessitating the leave permit.

Section 7. Worker's Compensation

The Worker's Compensation law provides protection for employees experiencing occupational disabilities through accidents or by exposure to disease arising out of and in the course of employment.

1. When an employee suffers an on-the-job injury or exposure, whether or not medical attention is required, a "Report of Injury" form must be completed by the employee and forwarded to both the Insurance Coordinator and up the chain of command as soon as possible.

2. All expenses involved with the treatment of the exposure or injury are covered by the Illinois Worker's Compensation Act. That Act provides payment of sixty six and two-thirds (66 2/3) of the employee's wages for lost time at work after a three (3) day waiting period. If the employee is off work for more than fourteen (14) days because of a job-related injury or

exposure, then the employee will be compensated for the waiting period. In addition to this partial payment of wages pursuant to the Illinois Workers' Compensation Act (hereinafter referred to as "The Act"), employees with more than one (1) year of service with the County will also receive a minimal amount of disability through IMRF.

The County, in addition to compliance with the Act, shall pay an additional one-third (1/3) of the average weekly wage to employees for the first thirty (30) days that the employee is totally disabled. This is a voluntary payment by the County and by accepting such payments; employees shall recognize and will assist the County in enforcing its subrogation rights.

Nothing in this policy shall be construed as limiting or contravening the Public Employee Disability Act, 5 ILCS 345/1.

Section 8. Jury Duty/Work-Related Court Duty

Court leave shall be granted to employees who are called to jury duty or are required to be absent from work because of subpoena from any legislative, judicial, or administrative tribunal. Time away from work with pay shall be granted for such purposes. All compensation received for court or jury shall be remitted by the employees to the County Auditor, to be returned to the County Treasurer from which the original payroll warrant was drawn. The County feels that by volunteering to appear as a witness, an employee may create the impression that the County favors one (1) litigant to the detriment of the other. Therefore, to avoid any suspicion of favoritism, County employees are instructed not to appear as a witness unless properly subpoenaed.

Section 9. Funeral/Bereavement Leave

In the event of a death in an employee's immediate family, the employee will be allowed up to three (3) days leave with pay for the time actually lost. Immediate family members are defined as including the employee's children (including step and adopted), father, mother, current spouse, brother, sister, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparents and grandchildren.

These days will not be deducted from sick pay. Employees must notify their immediate supervisor of the death, relationship to the deceased and expected time of absence. Any additional time off beyond three (3) days will be granted at the sole discretion of the Sheriff or his designee and will be deducted from the employee's unused vacation time, personal/sick time or comp time.

In addition to the above provisions, the Illinois Family Bereavement Leave Act provides that all eligible employees shall be entitled to use a maximum of 2 weeks (10 working days) of unpaid bereavement leave to (1) attend the funeral or alternative to a funeral of a "covered family member" under the Act, (2) make arrangements necessitated by the death of a "covered family member," (3) grieve the death of a "covered family member," or (4) be absent from work due to a miscarriage, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed

adoption match or an adoption that is not finalized because it is contested by another party, a failed surrogacy agreement, a diagnosis that negatively impacts pregnancy or fertility, or a stillbirth. Pursuant to the Act, a "covered family member" means an employee's child, stepchild, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent. In the event of the death of more than one "covered family member" in a 12-month period, the employee is entitled to a total of 6 (six) weeks of bereavement leave during that 12-month period. All family bereavement leaves will be granted in accordance with the Family Bereavement Leave Act. Leaves must be completed within 60 days after the date on which the employee receives notice of the death of the covered family member.

ARTICLE 18
UNION RIGHTS

Section 1. Union Activity During Working Hours

Employees shall be allowed necessary and reasonable time off with pay during working hours to attend committee meetings, negotiations, and other necessary and reasonable activities so long as they have been established by this Agreement, and/or other meetings called or agreed to by the Employer if such employees are entitled or required to attend such meetings by virtue of being participants.

Section 2. Access to Premises by Union Representatives

The Employer agrees that local representatives and officers and Union staff representatives shall have reasonable access to the premises of the Employer, giving notice upon arrival to the appropriate Employer representative. Such visitations shall be for the reason of the administration of this Agreement. By mutual agreement with the Employer in emergency situations, Union staff representatives or Local Union representatives may call a meeting during work hours to prevent, resolve or clarify a problem.

Section 3. Union Bulletin Boards

The Employer shall provide bulletin boards and/or space at each work location.

Section 4. Information Provided to Union

The Employer shall notify the Union in writing of the following personnel transactions involving bargaining unit employees as they occur: New hires, promotions, layoffs, reemployment, transfers, leaves, returns from leave, suspension, discharge and termination.

At the request of the Union, the Employer shall furnish the Union a current seniority roster and reemployment lists, applicable under the seniority provisions of this Agreement.

Section 5. Union Orientation

Each newly hired bargaining unit employee shall, during the employee's first (1st) day of employment, subject to operational needs, be scheduled at a time mutually agreeable

to the parties, for an orientation which shall be provided by the Union. The Union orientation period shall be a maximum of one (1) hour and shall take place during the employee's regular working hours with no loss of pay to the employees involved.

Section 6. Distribution of Union Literature

During employee's non-working hours, he/she shall be permitted to distribute Union literature to other non-working employees in non-work areas and in work areas during non-work hours.

Section 7. Union Meetings on Premises

The Employer agrees to make available conference and meeting rooms for Union meetings upon prior notification by the designated Union representative, unless to do so would interfere with the operating needs of the Employer, or cause additional cost or undue inconvenience to the Employer. The Sheriff will provide the Union space for a computer outlet, desk, and filing cabinet on the premises.

Section 8. Rate of Pay

Any time off with pay provided for under this Article shall be at the employee's regular rate of pay as though the employee were working, not to exceed the employee's regular working scheduled hours.

ARTICLE 19
WAGES

Section 1. Wage Schedule

Employees shall be compensated in accordance with the wage schedule attached to this Agreement and marked Appendix B. The attached wage schedule shall be considered part of this Agreement.

Section 2. Pay Period

Employees are paid on a bi-weekly schedule. Each payroll period shall consist of fourteen (14) calendar days, so that the bi-weekly rate of pay of each employee shall be one twenty-sixth (1/26th) of the employee's annual salary. In a year in which twenty-seven (27) pay periods shall occur, the bi-weekly rate of pay for each employee shall be one twenty-seventh (1/27th) of the annual salary. When a payday falls on a holiday, the paycheck is distributed the preceding workday. Employees are encouraged to sign up for direct deposit of their paychecks through Payroll in the Human Resources Management Department.

Section 3. Uniform Allowance

All regular full-time employees will be given a uniform allowance of one thousand five hundred dollars ($1,500.00). The employees' uniform allowance of one thousand five hundred dollars ($1,500.00) per year shall be evenly divided and paid on the first regular

payroll checks in December and June of each year. The employee must complete a one (1) year probationary period and wait for the subsequent date of issuance prior to receiving uniform allowance. Until an employee receives the uniform allowance, the Sheriff's Office is responsible to supply and repair or replace, if damaged in the line of duty, at no cost to the employee, all items required for a proper uniform. In addition, the Employer shall supply one bullet proof vest for new full-time employees upon hire. Employees must return all issued uniforms and equipment if employment with the Sheriff's Office ends within his/her first (1st) year of hire.

Section 4. Other Pay Provisions

1. Interpreter/Bilingual Sergeants – One Hundred dollars ($100.00) per month

Any Sergeant who is fluent in Spanish, sign language, Polish or other foreign language(s) and who proves certification of said language(s) by letter from a third-party vendor approved by the Sheriff shall receive additional compensation of one hundred dollars ($100.00) per month upon assignment by the Sheriff.

2. Range Instructors – One Hundred dollars ($100.00) per month

Range Instructors who are assigned and state certified as range instructors shall receive this specialty pay. All range instructors shall be allowed to attend a certified training program, provided such programs are available locally and funding is available.

3. Field Training Sergeant – One Hundred Seventy-Five dollars ($175.00) per month

Field Training Sergeants who are assigned by the Sheriff and are state-certified as training officers shall receive additional compensation of one hundred seventy-five ($175.00) per month upon assignment by the Sheriff. All training officers shall be allowed to attend a certified training program, provided such programs are available locally and funding is available.

As with all assignments, the above specialty assignments are at the sole discretion of the Sheriff. Employees shall be eligible for multiple assignments.

Section 5. Meal Allowance

Employees assigned to travel greater than twenty-one (21) miles from the Sheriff's Office, whether for training or otherwise, shall be provided meal allowances if they are also required to work outside their eight (8) hour workday in conjunction with the travel. Voluntary request for training made by Employees shall waive meal allowance benefit to facilitate training in the agency.

1. Employees who are required to travel, as stated above, outside their regular eight (8) hour workday, but who are not required to stay overnight. Amount shall be determined in accordance with County per diem guidelines.

2. Employees who are required to travel, as stated above, outside their regular eight (8) hour workday and who are additionally required to stay overnight. Amount shall be determined in accordance with County per diem guidelines.

Section 6. Travel Time/Vehicle Usage

If the Sheriff approves training for an employee, the sheriff agrees to pay for travel time by automobile to said training in all cases whereby the training facility is more than twenty-one (21) miles from the Sheriff's Office. Voluntary request for training made by Employees shall waive the twenty-one (21) mile travel time benefit to facilitate training in the agency.

Employer shall provide a vehicle for use to travel back and forth to all training. This section shall comply with current Sheriff's Office policy for vehicle usage.

Section 7. Callback/Callout

Callback/callout is defined as an official assignment of work which does not continuously precede or follow an employee's regularly scheduled working hours. When an employee is called out/back by the Employer outside his/her normal work schedule by the Sheriff or his designee, he/she will be compensated at a rate of time and one-half (1 1/2) pay with a two (2) hour minimum.

ARTICLE 20
OUT OF TITLE WORK

The Sheriff may temporarily assign an employee to perform the duties of another employee.

Employees who are assigned to perform a significant number of duties of another employee for more than five (5) consecutive working days (counted individually and cumulatively) from the start to the end of the entire period shall be paid the greater of the following:

1. The pay of the employee whose duties the assigned employee is performing, or

2. The current pay of the assigned employee, after said five (5) day period.

ARTICLE 21
INSURANCE

Section 1. Medical, Vision and Dental Coverage

1. The Employer shall provide comprehensive group insurance programs for hospitalization, medical, vision and dental coverage (collectively referred

to as "health insurance coverage") for each eligible employee who chooses to participate and the employee's eligible dependents similar to the coverage which is currently in effect. Plan design changes for 2023 are included in Appendix G attached hereto and incorporated herein. All regular full-time employees are eligible to enroll in the County's comprehensive group health insurance plans.

2. The costs of the insurance programs are shared by full-time employees and the County, with the employee share paid through payroll deductions. A pre-tax deduction Section 125 Plan is available at the time of enrollment. The overall aggregate cost of the County's health insurance programs shall be shared by the County and the Union and non-Union employees at the overall aggregate rate of eighty-three percent (83%) borne by the County and seventeen percent (17%) borne by the Union and non-Union employees. It is understood that individual rates and percentage contribution levels will vary across plans and will be based on an employee's plan selection each year, but the overall aggregate percentage rates borne by the County, on the one hand, and the Union and non-Union employees, on the other shall remain the same through December 31, 2025.

3. The County reserves the right to self-insure, change carriers and engage in cost containment measures during the term of this Agreement so long as the benefits and coverages sought are substantially similar to those being currently offered.

4. The parties agree to continue the implementation of a Wellness Program for employees and spouses covered by the County's health insurance plans. Participation in the Wellness Program shall be defined as participating in an annual health evaluation which shall continue to be limited to completing an assessment, providing a blood sample, and receiving a health evaluation report. No other additional action on the part of any employee or spouse shall be required. The Employers agree that participation (or non-participation) in the Wellness Program shall not be used in any way to initiate or support an employment action of any kind. The parties further agree that accommodations shall be made to facilitate participation of retired employees that reside outside of Kane County. Participation in the Wellness Program shall not require or constitute any waiver of an individual's right to privacy under HIPAA, or other applicable laws. If an employee participates in the Wellness Program, the Employee will pay $50 less per month towards the cost of group health insurance than an employee who does not participate. If the Employee's spouse is covered by the County's health insurance plan, and the spouse participates in the Wellness Program, the Employee will pay $50 less towards health insurance costs than an Employee whose spouse does not participate. If both the employee and the spouse participate in the Wellness Program, the Employee will pay $100 less per month towards the cost of health insurance than a couple who does not participate. Children are not eligible to participate in the Wellness Program and thus are not eligible to earn a discount.

Section 2. Future Plans

Should the County adopt plans or policies which affect Employee's insurance benefits (including what is commonly referred to as a flexible benefit program), Union employees of the Employer shall have the option to participate in the same plans or programs in the same manner as other County Employees.

In addition, in the event the County agrees to a lower overall contribution for non-Union employees who participate in County plan(s), the lower overall contribution rate shall apply to employees covered by this Agreement.

Section 3. Life Insurance

The County will provide information concerning any available additional life insurance through IMRF and at the request of the employee shall make such necessary deductions from the employee's paycheck.

Section 4. Health Care Continuation Coverage for Retirees, Medicare Eligible Retirees and Disabled Employees

1. Retirees

With respect to non-Medicare eligible retiree employees, the County shall pay ten percent (10%) of the cost of continued medical insurance benefits under the same terms and for the same coverage as the employee received for the twelve (12) months preceding retirement.

Employees retiring under regular IMRF must be at least fifty-five (55) years of age with at least eight (8) years of service. Sheriff's Law Enforcement Personnel (SLEP) members who retire (at any age) must have at least twenty (20) years of SLEP credit.

In order to be eligible for the ten percent (10%) reduction, an employee must have been employed by the Employer for fifteen (15) or more consecutive years.

Retired employees who wish to take advantage of this medical insurance must pay ninety percent (90%) of the premium for either single or dependent coverage. The premium is due on the first (1st) of each month and must be submitted to Human Resources in order for coverage to be maintained.

2. Medicare Eligible Retirees, Disabled Employees and Surviving Spouses-

Kane County offers a reduced benefit PPO health care plan to Medicare eligible retirees, disabled employees and surviving spouses. The PPO plan includes a separate deductible of five hundred dollars ($500) for outpatient drugs to be paid at eighty percent (80%) (coinsurance does not go towards the outpatient prescription maximum). The full amount of the premium that must be paid is established by the County Board each year.

3. Retirees -- Annual Open Enrollment --

Retired employees may elect to change medical insurance plans during the annual open enrollment period for active county employees each year.

ARTICLE 22
VACANCIES

Section 1. Determination of Vacancies

The Sheriff shall solely determine when a vacancy exists and whether or not to fill the vacancy.

Section 2. Posting

Whenever shift vacancy occurs, other than a temporary vacancy as defined below, in any existing job classification or as a result of the development or establishment of new job classifications, a notice of such vacancy shall be posted on all bulletin boards for ten (10) working days. Temporary vacancies are defined as job vacancies that may periodically develop in any job classification that do not exceed thirty (30) consecutive days. Job openings that remain open more than thirty (30) consecutive days at a time shall not be considered temporary job openings.

During this period, employees who wish to apply for the vacant shift assignment, including employees on layoff, may do so.

Section 3. Selection

The Sheriff, or his designee, shall be the sole person to select those persons to fill vacancies. Provided, however, in making the selection, the Sheriff or his designee shall give consideration to factors such as seniority, experience, training, proven ability, demeanor, evaluations, and any other evidence brought to the Sheriff's attention which impacts on the criteria which relates to the vacancy.

ARTICLE 23
SAFETY AND HEALTH

Section 1. General Duty

The Employer and Union shall cooperate so that the Employer can continue its efforts to provide for a safe working environment, including tools and equipment, for its employees as is legally required by federal and state laws.

Section 2. Limitation

The parties agree that grievances alleging violation of Section 1 of this Article may be processed to Step 3 of the Grievance Procedure of this Agreement and will be subject to the Grievance Arbitration procedure.

Section 3. Safety Committee

Two (2) employees designated by the Union and two (2) persons designated by the Employer shall comprise safety committee for the purpose of discussing safety and health issues relating to employees and to recommend reasonable safety and health criteria relating to equipment and facilities. The committee will meet on a reasonable basis at a mutually agreed time. Employees attending a committee meeting will be paid if the meeting is scheduled during an employee's working hours. Formal recommendations of the committee shall be submitted in writing to the Sheriff with a copy to the Union, but shall not be binding upon the Employer or the Union.

Section 4. Fitness for Duty Evaluation

Employees may be required to undergo a physical or psychological fitness for duty evaluation by the Sheriff, or his or her designee, where there is a reasonable belief that an employee may not be physically, emotionally or mentally fit to carry out his or her essential job duties. Determining that a fitness for duty evaluation is warranted shall be made by the Sheriff or his/her designee, in accordance with GO-10-01. The basis for the determination shall be set forth in writing to the employee ten (10) days prior to the time the employee is to undergo such testing. However, the ten (10) day notice shall be waived when the employee's conduct imminently or directly threatens the safety to self or others. In that case, a copy shall be given to the employee at the time the employee is ordered to undergo such evaluation.

All examinations and inquiries into an employee's fitness for duty shall be both job-related and consistent with operational necessity and shall be no broader or more intrusive than deemed necessary by qualified, licensed and certified medical doctors, psychiatrists or psychologists.

An Employee shall have the right to inform the Union of the order after it is received and shall have the right to secure a similar fitness for duty evaluation at the employee's own expense from a qualified, licensed and certified medical doctor, psychiatrist or psychologist of their own choosing.

The Employee shall sign any and all releases or authorizations required by the medical doctor, psychiatrist, or psychologist, as the case may be, to release the information and evaluation obtained as a result of a fitness for duty evaluation to the Employer. The Employer recognizes the employee's right to privacy and agrees that any information and evaluation obtained pursuant to this section shall be placed in the employee's secure medical file. The evaluation and information provided to the Employer as a result of such fitness for duty evaluation shall be provided to the employee.

In the event the Employer seeks to terminate an employee covered under this Agreement, based on the fitness for duty evaluation and other information obtained pursuant to GO-10-01, the Sheriff or his/her designee shall meet with the employee involved and inform the employee of the contemplated action and the reason thereof. The employee shall be informed of his/her contract rights to Union representation and shall be entitled to such, if so requested by the employee. If the Employer and the Employee are

unable to agree to the findings of the fitness for duty examination, the doctors representing the employee and the Employer shall pick a third-party qualified physician in that field to arbitrate the decision. The physician can be chosen from a list of area physicians qualified in that practice.

Section 5. Drug and Alcohol Testing

See Appendix C Reference Drug and Alcohol Testing procedures.

The parties agree to continue to discuss the language of Section 8. of Appendix C. "Voluntary Requests for Assistance and Discipline and incorporate changes via a Memorandum of Understanding.

ARTICLE 24
HOURS OF WORK

Section 1. Hours/Overtime

1. Workweek/Period: The workweek is a one-hundred and sixty-eight (168) hour period beginning at 0001 hours on Sunday and ending at 2359 hours the following Saturday. The regular hours for the work period shall consist of forty (40) hours beginning at 0001 hours on a designated Sunday and ending seven days later at 2359 hours on Saturday. Time worked shall be defined according to the Fair Labor Standards Act.

2. Overtime: Overtime is defined as all pre-authorized work in excess of eight (8) hours in a single workday. Overtime work shall be rounded to the nearest quarter (1/4) hour. Time spent on sick leave, vacations or authorized leave shall not be considered hours worked in computing overtime. However, holidays and compensatory time off shall be considered hours worked in computing overtime. Overtime shall be paid at the rate of one and one-half (1 ½) times an employee's base rate of pay.

Section 2. General Provisions for All Employees

1. "The Workday and the Workweek": The normal workday shall consist of eight (8) consecutive hours to be broken at approximately mid-point by a meal period plus one (1) paid fifteen (15) minute rest period. The normal workweek shall consist of five (5) consecutive workdays followed by two (2) consecutive days off. (See Appendix E.)

2. "Meal Periods": Work schedules shall provide for the workday to be broken at approximately mid-point by an uninterrupted forty-five (45) minute meal period, which is to be given in accordance with current practice for employees who are regularly scheduled to work forty (40) hours per week. They shall then receive one (1) fifteen (15) minute rest period during the last half of their shift. Employees shall have the right to leave the work site for their approved meals, and they will notify the Lieutenant of Court Security, or his/her designee, as to both their departure and arrival in the

facility. The Employer will only deny this right when operations would be adversely impacted.

Section 3. Scheduling Practices

Employees will bid for shift preference based on classification seniority once per year or whenever duty assignments are changed as part of a regular rotation of assignment. The annual shift bid process shall be completed prior to the bidding for vacation periods as described in Article 16, Section 4 (October 1).

There will essentially be three "Shifts": "Early Shift", "Day Shift", and "Afternoon Shift" with start times to accommodate the court schedule as set by the judiciary.

"Early Shift" and "Day Shift" Sergeants will rotate shifts every two (2) weeks.

Employees can switch shifts with prior approval from Lieutenant of Court Security, or his/her designee.

"Afternoon Shift" shall cover the "Day Shift" slot when an employee has scheduled time off with a five (5) day notice.

APPENDIX E sets forth the scheduling practices that prevail at the signing of this Agreement. Hereinafter, when changes to the scheduling practices are sought by the Sheriff to accommodate the court schedule, as set by the judiciary, except in an emergency (including court orders), the Sheriff shall notify and shall discuss the reasons for such changes with the Union within forty-five (45) calendar days (or as soon as practicable in the case of an emergency) prior to the effective date of the changes. In addition, except for emergencies as set forth above, the Sheriff shall notify the affected employees twenty-eight (28) calendar days prior to the change or as soon as practicable in the case of an emergency.

Section 4. Overtime Procedure

Overtime shall be distributed as equally as possible among the employees who normally perform the work in the position classification in which the overtime is needed.

Compulsory (ordered) overtime will be done in a reverse seniority method, starting with the least senior Sergeant to the most senior Sergeant. There will be a separate list kept from the regular overtime list. Once an employee has been ordered to work overtime and performs such work, that employee will rotate to the bottom of the list. In the case of exigent circumstances (i.e., employee illness, previously scheduled medical appointment, child care issues), an employee may seek relief from working the ordered overtime by finding an alternate employee to fulfill the overtime obligation; provided, however, the ordered employee shall be responsible for finding his/her replacement and notifying the supervisor who ordered the overtime. The ordered employee shall remain at the top the compulsory overtime list and will remain at the top of list until he/she fulfills the overtime obligation. An employee who fulfills another ordered employee's compulsory overtime obligation will rotate to the bottom of the compulsory overtime list.

Section 5. Compensatory Time

Employees may choose to accumulate compensatory time at the applicable rate. Such compensatory time may accumulate up to two hundred and forty (240) hours per year. After the maximum accumulation has been reached, overtime in excess of forty (40) hours in a workweek shall be paid in cash at the rate of one and one-half (1-1/2) times the employee's regular rate. All reasonable efforts will be made to accommodate an employee's request to utilize accumulated compensatory time off.

ARTICLE 25
SUBCONTRACTING

Section 1. General Policy

It is the general policy of the Employer to continue to utilize employees to perform work for which they are qualified to perform. The Employer reserves the right to contract out any work that it deems necessary in the interest of economy, improved work product or emergency.

Section 2. Notice and Discussion

Absent an emergency situation, prior to the Employer changing its policy involving the overall subcontracting of work in a bargaining unit area, when such change amounts to a significant deviation from past practice resulting in loss of work of bargaining unit employees, the Employer shall notify the Union and offer the Union an opportunity to discuss and participate in considerations over the desirability of such subcontracting of work, including means by which to minimize the impact of such on employees.

Prior to subcontracting of bargaining unit work, the Employer, the Union, and the proposed sub-contractor shall meet to discuss the employment of employees subject to layoff. The Employer will request that the sub-contractor hire laid off employees.

ARTICLE 26
MANAGEMENT

Except as specifically limited by the express provisions of this Agreement, the Employer retains traditional rights to manage all affairs of the Sheriff's Office, as well as those rights set forth in the Illinois Public Labor Relations Act. Such management rights shall include but are not limited to the following:

1. To plan, direct, control and determine all operations and services of the County Sheriff's Office;

2. To supervise and direct employees;

3. To establish the qualifications for employment and to decide which applicants will be employed;

4. To establish reasonable work rules and work schedules and to assign work as the Employer deems necessary. Such work rules and schedule shall be posted in a place and manner as mutually agreeable to the Employer and the Union;

5. To hire, promote, demote, transfer, schedule and assign employees to positions and to create, combine, modify and eliminate positions within the County Sheriff's Office;

6. To suspend, discharge and take such other disciplinary action against employees for just cause (probationary employees with cause);

7. To establish reasonable work and productivity standards and, from time to time, amend such standards;

8. To lay off employees;

9. To maintain efficiency of County Sheriff's Office operations and services;

10. To determine methods, means, organization and number of personnel by which such operations and services shall be provided;

11. To take whatever action is necessary to comply with all applicable state and federal laws;

12. To change or eliminate methods, equipment and facilities for the improvement of operations;

13. To determine the kinds and amounts of services to be performed as it pertains to operations and the number and kind of Classifications to perform such services;

14. To contract out for goods and/or services;

15. To take whatever action is necessary to carry out the functions of the County Sheriff's Office in emergency situations.

ARTICLE 27
COMPLETE AGREEMENT AND MAINTENACE OF STANDARDS

Section 1. Complete Agreement

The parties acknowledge that during the negotiations which preceded this Agreement, each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining. The understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. Except as otherwise provided in this Agreement, the Employer and the Union, for life of this Agreement, each voluntarily

and unqualifiedly waive the right, and each agrees that the other shall not be obligated to bargain collectively with respect to:

1. any subject matter or matter specifically referred to or covered in this Agreement; and

2. subjects or matters that arose as a result of the parties' proposals during bargaining but which were not agreed to.

Section 2. Maintenance of Standards

The Employer agrees that if during the term of this Agreement, it enters into any new agreement with any Union or employee group considered to be a county department providing for increased fringe benefits greater than those provided herein (fringe benefits are defined as health and life insurance, and tuition reimbursement) the Employer shall notify the Union and upon request negotiate with the Union concerning the application of the fringe benefit to the bargaining units. However, it is the intent of the Employer not to provide such increased fringe benefit to other Union or County Departments without making the same provisions available to the bargaining units.

ARTICLE 28
PANDEMIC OR EMERGENCY CRISIS

Emergencies: In the event of a pandemic or other emergency crisis, as declared by State, Federal, or local officials in accordance with applicable law, which affects Kane County, the Employer and Union shall immediately meet to discuss how such crisis may affect bargaining unit members in relation to pay, working hours, safety, unemployment compensation, etc. The Employer and the Union will begin immediate discussions on any and all issues and shall work in an effort to address and resolve any problems that may result from such pandemic or other emergency crisis.

ARTICLE 29
DURATION AND TERMINATION

Section 1. Term of Agreement

This Agreement shall remain in full force and effect beginning on January 1, 2023, through December 31, 2025. It shall continue in effect from year to year thereafter unless notice of desire to terminate, amend or modify this Agreement is given in writing by certified mail, return receipt requested, by either party to the other not more than one hundred and twenty (120) days or less than ninety (90) days prior to the expiration of this Agreement. The notices referred to shall be considered to have been given as of the date shown on the postmark. Written notice may be tendered in person, in which case the date of notice shall be the written date of receipt.

Section 2. Continuing Effect

Notwithstanding any provision of this Article or Agreement to the contrary, this Agreement shall remain in full force and effect after any expiration date while negotiations

or Resolution of Grievances are continuing for a new Agreement or part thereof between the parties.

Section 3. Procedure on Notice of Termination

The parties agree that if either side decides to reopen negotiations upon termination, making any changes in the Agreement, either party may so notify the other in writing by certified mail, not more than one hundred and twenty (120) days or less than ninety (90) days prior to the expiration of this Agreement. In the event such notice to negotiate is given, then the parties shall meet no later than ten (10) days after the date of receipt of such notice, or at such reasonable times as are agreeable to both parties for the purposes of negotiations. All notices provided for in this Agreement shall be served upon the other party by certified mail, return receipt requested, or tendered in person, in which case the date of notice shall be the written date of receipt.

IN WITNESS WHEREOF, the parties hereto have affixed their signatures as of this 22 day of March, 2023.

FOR THE EMPLOYER:

Ronald Hain
Sheriff of Kane County

Corinne Pierog
Chairman, Kane County Board

FOR THE UNION:

Dominic Romanazzi
President, Teamsters Local 330

APPENDIX A
COURT SECURITY SERGEANT
CLASSIFICATION SENIORITY LIST

SERGEANTS

	Starting Date (as Sgt.)	Badge Number	Sergeant
1	06/25/2010	675	Chad Calhoun
2	01/11/2019	672	Derek Feiza
3	08/10/2020	634	Richard Malott
4	09/13/2021	668	Matthew Gabrielson

APPENDIX B
WAGES

Upon the effective date of this Agreement, employees shall receive a salary adjustment of ten thousand dollars ($10,000.00).

Effective January 1, 2023, the starting salary for Court Security Sergeant is $76,472.

Effective January 1, 2024, the starting salary for Court Security Sergeants is $79,530.

Effective January 1, 2025, the starting salary for Court Security Sergeants is $82,711.

Additionally, employees on the payroll on the dates listed below will receive the following raises:

(a) 1/1/24 – 4% increase

(b) 1/1/25 – 4% increase

During the term of this CBA only, bargaining unit employees employed by the Sheriff as of the dates set forth below will receive the following one-time, lump-sum supervisor stipend payments, less taxes, as follows:

(a) $2,500: Payable within 60 days following execution of this collective bargaining agreement via regular payroll.

(b) $2,500: Payable on the first regular payroll in January 2024.

APPENDIX C
DRUG AND ALCOHOL TESTING

Section 1. Statement of Policy

It is the policy of the Employer that the public has a reasonable right to expect the employees of the Sheriff's Office to be free from the effects of drugs and alcohol and have the physical stamina and emotional stability to perform their assigned duties. The Employer has the right to expect its employees to report for work fit and able for duty. The purposes of this policy shall be achieved in such manner as not to violate any rights of the employees established in this Agreement.

Section 2. Prohibitions

Unless assigned to an investigative unit which requires the conduct set forth below, Sheriff employees shall be prohibited from:

(a) being under the influence of alcohol or illegal or illegally obtained drugs during the course of their workday;

(b) consuming or possessing alcohol, except as may be necessary in the performance of their duty, at any time during the workday, or anywhere on the Employer's premises or work sites, buildings or properties or any vehicle owned by the employer or any vehicle not owned by the Employer but used in service to the Employer;

(c) the unlawful manufacture, possession, use, sale, purchase, dispensation, or delivery of any illegal drug at any time and at any place except as may be necessary in the performance of duty;

(d) failing to report to their supervisor any adverse side effects of medication or prescription drugs that the employee knows could interfere with the performance of his or her job duties;

(e) intentionally tampering with, substituting for, or causing another person to tamper with, substitute for a urine and/or blood specimen.

Violation of the above-referenced prohibitions shall be cause for discipline, up to and including discharge.

Section 3. Drug and Alcohol Testing Permitted

Testing is permitted where the Employer has reasonable suspicion to believe.

(a) that an employee is under the influence of alcohol or illegal drugs during the course of the workday;

(b) has abused prescribed drugs; or

(c) has used illegal or illegally obtained drugs.

(d) employee appears to be unable to perform his/her job safely.

The Employer shall have the right to require the employee to submit to alcohol or drug testing as set forth in this Agreement. The Employer may also require an employee to randomly submit to alcohol or drug testing where the employee is assigned to a departmental drug enforcement group for a period of at least thirty (30) days and where such employee's duties are primarily related to drug enforcement. The Employer may require any employee accepting an assignment requiring a commercial driver's license to submit to alcohol or drug testing as may be permitted by law. At least two (2) supervisory personnel must state their reasonable suspicions concerning an affected employee prior to any direction to submit the employee to the testing authorized herein. The foregoing shall not limit the right of the Employer to conduct any tests it may deem appropriate for persons seeking employment with the Sheriff's Office, transfer or upon promotion to another position within the Office.

Section 4. Order to Submit to Reasonable Suspicion Testing

At the time an employee is directed to submit to testing as authorized by this Agreement, the Employer shall provide the employee with oral notice briefly outlining the reasonable suspicion leading to the request. Within seventy-two (72) hours of the time an employee is ordered to submit to testing authorized by this Agreement, the Employer shall provide the employee and the Union with a written notice setting forth the facts and inferences which form the basis of the order to test. Refusal to submit to such test may subject the employee to discipline, but the employee's taking of the test shall not be construed as a waiver of any objection or rights that he may possess.

Section 5. Random Drug Testing

(a) All employees of this bargaining unit will be subject to Random Drug Testing. Such testing will be during an employee's regularly scheduled shift.

(b) Upon notification that an employee is scheduled for Random Drug Testing, such employee will appear at the required location specified for the drug testing. **(See Drug Testing Locations Appendix D)**

(c) The employee must appear at the required location during their regularly scheduled shift, but not later than six (6) hours from the time they receive the notice.

(d) The employee will be required to show a photo identification card to the testing agency upon their arrival to verify their true identity before the testing procedure will begin. If the employee does not have a photo ID then the on-duty supervisor will be required to go to the location and verify the identity of the employee.

(e) The random selection process shall be by computer generated numbers for each sworn officer of the department. Such computer-generated program shall be

performed by an outside contractor hired by the Employer after consultation with the Union. The outside contractor shall be one that specializes in such functions.

(f) The outside contractor shall not select more than four (4) Sheriff's employees from the computer-generated list per month for random drug testing.

(g) The dates for said tests shall also be chosen at random by the same outside contractor. To maintain the security of the selection process, the contractor shall deal only with the Sheriff or, in the Sheriff's absence, a designee for purposes of notifying the Sheriff of testing dates and individuals selected. The list of selected member(s) shall be provided to the Union after the testing dates for the affected member(s).

(h) On the same day the employee has been given notice for testing, the Union representative will also be notified that the employee has been selected. The Union representative shall insure only those employees originally selected were actually tested. The Sheriff or designee shall assist the Union representative in understanding any discrepancies.

(i) Immediately after being ordered, refusal to report for testing shall constitute insubordination and will result in the imposition of statutory and departmental rules, regulations and procedures concerning the imposition of discipline.

(j) An employee who tests positive after a random drug test shall be subject to the same conditions as those who test positive under "reasonable suspicion" drug test and shall be subject to discipline for any violations of Section 2.

(k) The random selection of a member will not result in the member's name being removed from any future selection process.

(l) If an officer is selected for a random test, but is unavailable due to extenuating circumstances, no disciplinary action will be taken (e.g., in court, on a surveillance, engaged in a police activity that the employee is participating in such as a drug raid, hostage situation, etc.). The test will be administered as soon as practicable after the employee is available.

Section 6. Tests to be Conducted

In conducting the testing authorized by this Agreement, the Employer shall:

(a) use only a clinical laboratory or hospital facility that is licensed pursuant to the Illinois Clinical Laboratory Act that has or is capable of being accredited by the National Institute of Drug Abuse (NIDA) and Department of Transportation (DOT)

(b) select a laboratory or facility that conforms to all NIDA standards and DOT;

(c) establish a chain of custody procedure for both the sample collection and testing that will ensure the integrity of the identity of each sample and test result;

(d) collect a sufficient sample of the bodily fluid or material from an employee to allow for initial screening, a confirmatory test and a sufficient amount to be set aside reserved for later testing, if requested by the employee;

(e) collect samples in such a manner as to preserve the individual employee's right to privacy, ensure a high degree of security for the sample and its freedom from adulteration;

(f) confirm any sample that tests positive in the initial screening for drugs by re-testing the second portion of the same sample by gas chromatography mass spectrometry (GCMS) or an equivalent or better scientifically accurate and accepted method that provides quantitative data about the detected drug or drug metabolites;

(g) provide the tested employee with the opportunity to have an additional sample tested by a clinical laboratory or hospital facility of the employee's own choosing, at the employee's own expense; provided the employee notifies the Employer within seventy-two (72) hours of receiving the results of the tests;

(h) require that a laboratory or hospital facility report to the Employer that a blood or urine sample is positive only if both the initial screening and the confirmation tests are positive for a particular drug. The parties agree that should any information concerning such testing or the results thereof be obtained by the Employer inconsistent with the understandings expressed herein (e.g., billings for testing that reveal the nature or number of the tests administered), the Employer will not use such information in any manner or forum adverse to the employee's interest;

(i) require that with regard to drug testing, for the purpose of determining whether the employee is under the influence of drugs on a five (5) panel drug test with test results higher than the following:

Amphetamines 1000ng/ml
Cocaine Metabolites 300ng/ml
Marijuana Metabolites 50ng/ml
Opiates 2000ng/ml
Phencyclidine 25ng/ml

those testing higher will be removed from safety sensitive positions.

(j) require that with regard to alcohol testing, for the purpose of determining whether the employee is under the influence of alcohol, test results showing an alcohol concentration of **.04** or more based upon the grams of alcohol per 100 milliliters of blood be considered positive (Note: the foregoing standard shall not preclude the Employer from attempt to show that test results between **.02 and .04** demonstrate that the employee was under the influence, but the Employer shall bear the burden of proof in such cases); those testing .04 or higher, will be removed from safety sensitive positions.

(k) provide the employee tested with a copy of all information and reports received by the Employer in connection with the testing and the results;

(l) ensure that no employee is the subject of any adverse employment action except emergency temporary assignment or relief of duty during the pendency of any testing procedure. Any such emergency reassignment or relief from duty shall be immediately discontinued in the event of a negative test result.

Section 7. Right to Contest

The Union or the employee, with or without the Union, shall have the right to file a grievance concerning any testing permitted by this Agreement, contesting the basis for the notice to submit to the tests, the right to test, the administration of the tests, significance and accuracy of the tests, the results or any other alleged violation of this Agreement. Such grievances shall be commenced at Step 2 of the Grievance Procedure. It is agreed that the parties in no way intend or have in any manner restricted, diminished or otherwise impaired any legal rights that employees may have with regard to such testing. Employees retain such rights as may exist and may pursue the same in their own discretion, with or without the assistance of the Union.

Section 8. Voluntary Requests for Assistance and Discipline

The Employer shall take no adverse employment action against any employee who voluntarily seeks treatment, counseling or other support for an alcohol or drug related problem, other than the Employer may require reassignment of the employee with pay if he is then unfit for duty in his current assignment. All such requests for assistance and/or referral to treatment shall remain confidential and any information received by the Employer concerning counseling, referral, and/or treatment shall not be used in any manner adverse to the employee's interest, except as described in this Agreement.

The foregoing is contingent upon:

(a) The alcohol or drug use at issue does not involve any illegal activity; and

(b) The employee agreeing to the appropriate treatment as determined by the physician(s) involved; and

(c) The employee discontinues his use of illegal drugs or abuse of alcohol; and

(d) The employee completes the course of treatment prescribed, including an "after-care" group for a period up to twenty-four (24) months; submits proof of completion; and

(e) The employee agrees to submit to random testing during hours of work during the period of "after-care."

Employees who do not agree to or who do not act in accordance with the foregoing, or test positive a second or subsequent time for the presence of illegal drugs or alcohol during hours of work shall be subject to discipline, up to and including discharge.

The foregoing shall not be construed as an obligation on the part of the Employer to retain an employee on active status throughout the period of rehabilitation if it is appropriately determined that the employee's current use of alcohol or drugs prevents such individual from performing his duties or whose continuance on active status would constitute a direct threat to the property or safety of others. Such employees shall use accumulated paid leave or take unpaid leave of absence, pending treatment.

APPENDIX D
DRUG TESTING LOCATIONS

Dreyer Medical Center
2500 West Fabyan Parkway
Batavia, IL 60510
8:00 a.m. to 5:00 p.m.
Monday through Friday

Testing Locations After Hours

Dreyer Medical Clinic
Aurora West Plaza Location
2358 Sequoia Dr.
Aurora, IL 60506
7:00 a.m. to 8:00 a.m.

APPENDIX E
SCHEDULING PRACTICES

Early Shift

630 to 1430	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Sergeant	DO	X	X	X	X	X	DO

Day Shift

0830 to 1630	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Sergeant	DO	X	X	X	X	X	DO

Afternoon Shift*

1200 to 2000	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Sergeant	DO	X	X	X	X	X	DO

Shall cover Day Shift slot when a Sergeant has a scheduled day off, with five (5) day notice.

APPENDIX F

TEAMSTERS LOCAL 330 GRIEVANCE FORM

EMPLOYEE'S INFORMATION

Name: _____ Phone: _____

Address: _____ Date: _____

_____

EMPLOYER INFORMATION

Employer: Kane County Sheriff Phone: _____

Address: _____

_____

Nature of Grievance: _____

_____

_____

_____

Settlement Request: _____

_____

_____

_____

_____

I hereby acknowledge discussing this matter at Step 1 of the grievance procedure.

Signed: _____

_____

Dated: _____

Page: _____ of _____

Lieutenant of Court Security

APPENDIX G
KANE COUNTY
HEALTH PLAN FEATURES

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, call 1-800-295-0593 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $750 Individual/$2,250 Family For Out-of-Network: $1,500 Individual/$4,500 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. Certain preventive care, services that charge a copay, prescription drugs, and emergency room services 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. 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 deductible for Out-of-Network hospital admission. 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?	For In-Network: $2,750 Individual/$8,250 Family For Out-of-Network: $5,500 Individual/$14,250 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-295-0593 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 In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit; deductible does not apply	40% coinsurance	Virtual Visits: $30/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order); deductible does not apply	$10 copay/prescription (retail); deductible does not apply	30-day supply at Retail 90-day supply at Mail Order Rx Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family For Out-of-Network drug provider, you are responsible for 50% of the eligible amount after the copayment. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order); deductible does not apply	$40 copay/prescription (retail); deductible does not apply	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order) deductible does not apply	$60 copay/prescription (retail); deductible does not apply	
	Specialty drugs	$60 copay/prescription (retail); deductible does not apply	Not Covered	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	$30 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit; deductible does not apply; 20% coinsurance for other outpatient services	40% coinsurance	PCP copay applies to psychotherapy office visit only. Preauthorization may be required; see your benefit booklet* for details. Virtual Visits: $30/visit; deductible does not apply. See your benefit booklet* for details.
	Inpatient services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization required.
If you are pregnant	Office visits	$30 PCP/$50 SPC copay/visit; deductible does not apply	40% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 15 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids for children 1 per ear every 24 months, for adults up to $2,500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits per calendar year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

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 plan at 1-800-295-0593, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross and Blue Shield of Illinois at 1-800-295-0593 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-295-0593.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-295-0593.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-295-0593.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-295-0593.

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**	**$750**
■ **Specialist copayment**	**$50**
■ **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	$750
Copayments	$30
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,810**

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

■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$50**
■ **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	$750
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,800**

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

■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$50**
■ **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	$750
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને મફત ભા.એમ. ફાટેકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánilwo'igíí, na'idilkidgo, ts'idá bee ná ahóóti'i' t'áá niik'e niká a'doolwoł dóó bína'idiłtkidígii bee nił h odoonih. Ata'dahalne'igíí bich'į' hodiilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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, call 1-800-892-2803 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual/$3,000 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-892-2803 for a list of participating 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.

⚠ 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
		Participating Provider (You will pay the least)	Non-Participating 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	$30 copay/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency and routine vision exams, are not covered.
	Specialist visit	$50 copay/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 30-day retail/90-day mail. RX Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order)	Not Covered	
	Specialty drugs	Applicable copay	Not Covered	Coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	Ground transportation only.
	Urgent care	$30 copay/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not Covered	Unlimited visits. Referral required.
	Inpatient services	$250 copay/admission	Not Covered	Unlimited days. Referral required.
If you are pregnant	Office visits	$30 PCP/$50 SPC copay/visit	Not Covered	Copay applies for the 1st prenatal visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$250 copay/admission	Not Covered	Referral required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	$30 copay/visit	Not Covered	60 visits combined for all therapies. Referral required.
	Habilitation services	$30 copay/visit	Not Covered	
	Skilled nursing care	$250 copay/admission	Not Covered	Excludes custodial care. Referral required.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Inpatient copay may apply. Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Custodial care
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Chiropractic care
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2,500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs (except when non-medically supervised)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

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 plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$250**
■ **Other copayment**	**$0**

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$250**
■ **Other copayment**	**$0**

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$250**
■ **Other copayment**	**$0**

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

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

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાચકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánilwo'igíí, na'ídilkidgo, ts'idá bee ná ahóóti'i' t'áá niik'e niká a'doolwoł dóó bína'ídílkidígíí bee nił h odoonih. Ata'dahalne'igíí bich'į' hodiilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставляемую на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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, call 1-800-892-2803 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual/$3,000 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-892-2803 for a list of participating 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.

⚠ 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
		Participating Provider (You will pay the least)	Non-Participating 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	$30 copay/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency and routine vision exams, are not covered.
	Specialist visit	$50 copay/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 30-day retail/90-day mail. RX Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order)	Not Covered	
	Specialty drugs	Applicable copay	Not Covered	Coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	Ground transportation only.
	Urgent care	$30 copay/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not Covered	Unlimited visits. Referral required.
	Inpatient services	$250 copay/admission	Not Covered	Unlimited days. Referral required.
If you are pregnant	Office visits	$30 copay/visit	Not Covered	Copay applies for the 1st prenatal visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$250 copay/admission	Not Covered	Referral required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	$30 copay/visit	Not Covered	60 visits combined for all therapies. Referral required.
	Habilitation services	$30 copay/visit	Not Covered	
	Skilled nursing care	$250 copay/admission	Not Covered	Excludes custodial care. Referral required.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Inpatient copay may apply. Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Custodial care
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Chiropractic care
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs (except when non-medically supervised)

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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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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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.

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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.

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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

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

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da bíká ánánilwo'ígíí, na'ídilkidgo, ts'idá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł dóó bína'idilkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodiilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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, call 1-800-295-0593 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $750 Individual/$2,250 Family For Out-of-Network: $1,500 Individual/$4,500 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. Certain preventive care, services that charge a copay, prescription drugs, and emergency room services 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. 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 deductible for Out-of-Network hospital admission. 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?	For In-Network: $3,000 Individual/$9,000 Family For Out-of-Network: $6,000 Individual/$18,000 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-295-0593 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
		In-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	$30 copay/visit; deductible does not apply	40% coinsurance	Virtual Visits: $30/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com.	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order); deductible does not apply	$10 copay/prescription (retail); deductible does not apply	30-day supply at Retail 90-day supply at Mail Order Rx Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family For Out-of-Network drug provider, you are responsible for 50% of the eligible amount after the copayment. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order); deductible does not apply	$40 copay/prescription (retail); deductible does not apply	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order); deductible does not apply	$60 copay/prescription (retail); deductible does not apply	
	Specialty drugs	$60 copay/prescription (retail); deductible does not apply	Not Covered	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$500 copay/visit; deductible does not apply	$500 copay/visit; deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	$30 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit; deductible does not apply; 20% coinsurance for other outpatient services	40% coinsurance	PCP copay applies to psychotherapy office visit only. Preauthorization may be required; see your benefit booklet* for details. Virtual Visits: $30/visit; deductible does not apply. See your benefit booklet* for details.
	Inpatient services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization required.
If you are pregnant	Office visits	$30 PCP/$50 SPC copay/visit; deductible does not apply	40% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 15 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids for children 1 per ear, every 24 months, for adults up to $2,500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits per calendar per year)

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Does this plan provide Minimum Essential Coverage? Yes
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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:
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Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-295-0593.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-295-0593.

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

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$750
■ Specialist copayment	$50
■ 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	$750
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,040**

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

■ The plan's overall deductible	$750
■ Specialist copayment	$50
■ 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	$750
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,800**

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

■ The plan's overall deductible	$750
■ Specialist copayment	$50
■ 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	$750
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

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

BlueCross BlueShield of Illinois

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Diné Navajo	T'áá ni, éí doodago ła'da bíká anánilwo'ígíí, na'ídíłkidgo, ts'idá bee ná ahóóti'i' t'áá niik'e nikú a'doołwoł dóó bina'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodiilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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, call 1-800-892-2803 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual/$3,000 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-892-2803 for a list of participating 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.

⚠ 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
		Participating Provider (You will pay the least)	Non-Participating 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	$30 copay/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency and routine vision exams, are not covered.
	Specialist visit	$50 copay/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 30-day retail/90-day mail. RX Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order)	Not Covered	
	Specialty drugs	Applicable copay	Not Covered	Coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	Ground transportation only.
	Urgent care	$30 copay/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not Covered	Unlimited visits. Referral required.
	Inpatient services	$250 copay/admission	Not Covered	Unlimited days. Referral required.
If you are pregnant	Office visits	$30 PCP/$50 SPC copay/visit	Not Covered	Copay applies for the 1st prenatal visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$250 copay/admission	Not Covered	Referral required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	$30 copay/visit	Not Covered	60 visits combined for all therapies. Referral required.
	Habilitation services	$30 copay/visit	Not Covered	
	Skilled nursing care	$250 copay/admission	Not Covered	Excludes custodial care. Referral required.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Inpatient copay may apply. Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Custodial care
- Dental care (Adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Chiropractic care
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2,500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs (except when non-medically supervised)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

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 plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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Diné Navajo	T'áá ni, éi doodago ła'da bíká anánilwo'igíí, na'ídílkidgo, ts'idá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł dóó bina'ídílkidígíí bee nił h odoonih. Ata'dahalne'igíí bich'į' hodíilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
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Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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, call 1-800-892-2803 or at www.bcbsil.com. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual/$3,000 Family Prescription drug expense limit: $500 Individual/$1,500 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?	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 1-800-892-2803 for a list of participating 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.

⚠ 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
		Participating Provider (You will pay the least)	Non-Participating 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	$30 copay/visit	Not Covered	Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency and routine vision exams, are not covered.
	Specialist visit	$50 copay/visit	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order)	Not Covered	Dispensing limit may apply to certain drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. 30-day retail/90-day mail. RX Out-of-Pocket Expense Limit: $500 Individual/$1,500 Family.
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order)	Not Covered	
	Specialty drugs	Applicable copay	Not Covered	Coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	Ground transportation only.
	Urgent care	$30 copay/visit	Not Covered	Must be affiliated with member's chosen medical group or referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	Referral required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not Covered	Unlimited visits. Referral required.
	Inpatient services	$250 copay/admission	Not Covered	Unlimited days. Referral required.
If you are pregnant	Office visits	$30 PCP/$50 SPC copay/visit	Not Covered	Copay applies for the 1st prenatal visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$250 copay/admission	Not Covered	Referral required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	$30 copay/visit	Not Covered	60 visits combined for all therapies. Referral required.
	Habilitation services	$30 copay/visit	Not Covered	
	Skilled nursing care	$250 copay/admission	Not Covered	Excludes custodial care. Referral required.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	No Charge	Not Covered	Inpatient copay may apply. Referral required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months at participating providers.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Custodial care
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Chiropractic care
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2,500 per ear every 24 months)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs (except when non-medically supervised)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

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 plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$50
■ Hospital (facility) copayment	$250
■ Other copayment	$0

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
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Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.