Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Board of Trustees of the EIT Health and Welfare Plans for Office & Miscellaneous, Building, Hotel, Sign & Maintenance & Administrative Employees

Coverage Period: 7/1/2023 – 6/30/2024
Coverage for: Individual + Family | Plan Type: PPO

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. NOTE: Information about the cost of this **plan** (called the **premium**) will be provided **separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.fundoffice.org or call 1-800-862-3386. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600**/individual/calendar year **$1,200**/family/calendar year	Generally, you must pay all 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. **Preventative Care** and Chiropractic services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't met the annual **deductible** amount. But a **copayment**, or **coinsurance**, may apply. For example, this plan covers certain **preventative services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventative services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	**In-Network Medical:** **$3,000**/individual or family/calendar year **Out-of-Network Medical:** **$5,000**/individual or family/calendar year **In-Network Prescription:** 2023: **$6,100**/individual or family 2024: **$6,450**/individual or 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 may 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?	**Co-payments** for certain services, **premiums**, **balance-billed** charges, non-PPO **co-insurance**, penalties for failure to obtain **preauthorization** for services, hearing aid PPO **co-insurance**, and health	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
	care this **plan** does not cover.	
Will you pay less if you use a network provider?	Yes. Visit www.bcbsil.com or call 1-800-810-2583 for a list of **network providers.**	This **plan** uses a provider network. You will pay less if you use a **provider** in the **plan**'s **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider**'s charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 **copay**/office visit	20% **coinsurance**	None
	Specialist visit	$60 **copay**/office visit	20% **coinsurance**	None
	Preventive care, screening, immunization	No charge	20% **coinsurance**	You may have to pay for services that aren't **preventative services**. Ask your provider if the services are **preventative services**, then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	10% **coinsurance**	20% **coinsurance**	None
	Imaging (CT/PET scans, MRIs)	10% **coinsurance**	20% **coinsurance**	None
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	$10/30-day prescription $20/90-day prescription	Not Covered	You can obtain two initial 30-day fills of a maintenance drug at any retail pharmacy. After the two initial fills, you must obtain a 90-day fill via CVS Mail Order or CVS Pharmacy.
	Preferred brand drugs	25% of cost; $30 min/$50 max **copay**/30-day prescription. 25% of cost; $60 min/$100 max.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
drug coverage is available at www.caremark.com or 1-800-566-5693		**copay**/90-day prescription.		Call 1-800-966-5772 for CVS Mail Order. 30-day supply for non-maintenance drugs can be filled at any in-network pharmacy. A penalty may be applied if a brand drug is requested when a generic is available. **Specialty drugs** must be filled through CVS Specialty Connect at 1-800-237-2767. $6,100/individual and family annual max. **out-of-pocket limit** on in-network prescriptions in 2023 and $6,450/individual and family annual max. **out-of-pocket limit** for 2024. Call CVS Caremark at 1-800-566-5693 for customer service.
	Non-preferred brand drugs	30% of cost; $50 min/$100 max. **copay**/30- day prescription. 30% of cost; $100 min/$200 max. **copay**/90-day prescription.	Not Covered	
	Specialty drugs	**Preferred Brand Specialty:** 25% of cost; $30 min/$50 max. **copay**/30-day prescription. 25% of cost; $60 min/$100 max. **copay**/90-day prescription. **Non-Preferred Brand Specialty:** 30% of cost; $50 min/$100 max. **copay**/30-day prescription. 30% of cost; $100 min/$200 max. **copay**/90-day prescription.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **coinsurance**	20% **coinsurance**	None
	Physician/surgeon fees	10% **coinsurance**	20% **coinsurance**	None
If you need immediate medical attention	**Emergency room care**	10% **coinsurance**	10% **coinsurance**	None
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	None
	Urgent care	10% **coinsurance**	20% **coinsurance**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% **coinsurance**	20% **coinsurance**	**Preauthorization** required at least 3 days prior to non-emergency admission or within 48 hours of emergency admission. Failure to obtain **preauthorization** for **out-of-network** services may result in a $200 penalty. **Childbirth**: **Preauthorization** required for hospital stays that exceed 48 hours/vaginal delivery; 96 hours/c-section. Call BCBSIL Medical Service Advisory at 1-800-635-1928 for further information.

* For more information about limitations and exceptions, see the **plan** or policy document at www.fundoffice.org or call 1-800-862-3386.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
	Physician/surgeon fees	10% **coinsurance**	20% **coinsurance**	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 **copay**/office visit	20% **coinsurance**	**Preauthorization** required at least 3 days prior to non-emergency inpatient admission or within 48 hours of emergency admission. Failure to obtain **preauthorization** for **out-of-network** services may result in a $200 penalty. Prior to inpatient mental health or substance abuse care, call BCBSIL Behavioral Health at 1-800-851-7498.
	Inpatient services	10% **coinsurance**	20% **coinsurance**	
If you are pregnant	Office visits	$25 **copay**/office visit	20% **coinsurance**	**Copay** applies to first prenatal visit/pregnancy only. Cost sharing does not apply for **preventative services**. Depending on the type of service, **deductible** and **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% **coinsurance**	20% **coinsurance**	
	Childbirth/delivery facility services	10% **coinsurance**	20% **coinsurance**	
If you need help recovering or have other special health needs	**Home health care**	10% **coinsurance**	20% **coinsurance**	Medical review required. Call BCBSIL at 1-800-862-3386.
	Rehabilitation services	10% **coinsurance**	20% **coinsurance**	30 visit limit/diagnosis/benefit period. Additional services over maximum require medical review. Call BCBSIL at 1-800-862-3386.
	Habilitation services	10% **coinsurance**	20% **coinsurance**	
	Skilled nursing care	10% **coinsurance**	20% **coinsurance**	Medical review required. Call BCBSIL at 1-800-862-3386.
	Durable medical equipment	10% **coinsurance**	20% **coinsurance**	Benefits are limited to items used to serve a medical purpose. Some **durable medical equipment (DME)** may require medical review. Call BCBSIL 1-800-862-3386.
	Hospice services	10% **coinsurance**	20% **coinsurance**	Medical review required. Life expectancy must be 6 months or less. Call BCBSIL at 1-800-862-3386.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge for ages 0 – 18 $30 **copay** for ages 19 - 26	$30 **copay**	Child must be an Eligible Dependent under the **Plan**. **Out-of-Network**: Children ages 19-26, **Plan** will reimburse up to $45 on one exam per year after the **copay** is satisfied. Call VSP at 1-800-877-7195.
	Children's glasses	$20 **copay**	$20 **copay** + 20% **coinsurance** for ages 0-18	Child must be an Eligible Dependent under the **Plan**. **In-Network**: Children ages 19-26 are responsible for frame costs above allowance. $175 frame allowance at any in-network doctor. $225 frame allowance on Featured Frames or any frame at VisionWorks. **Out-of-Network**: Children ages 19-26 reimbursement up to specified limits depending on the type of lens/frame. Call VSP at 1-800-877-7195.
	Children's dental check-up	No charge	No charge unless exceeds U&C charges	Child must be an Eligible Dependent under the **Plan**. **Child ages 0-18: Preventative services** do not apply to dental maximum. **Child ages 19-26: Preventative services** do apply to dental maximum. Call BCBSIL/DNoA at 1-800-862-3386.

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**.)		
• Bariatric surgery (except in cases of morbid obesity • Cosmetic surgery (unless corrects the effect of an injury, congenital deformity or deformity resulting from disease or is medically necessary	• Infertility treatment • Long-term care	• Weight loss programs (except in the cases of morbid obesity

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)		
• Acupuncture (30 visit limit/calendar year • Chiropractic care (30 visit limit/calendar year) • Dental Care (Adult and Children) • Hearing aids ($75 exam, 80% of $2,500 per ear, $4,000 maximum benefit every 60 months not to exceed 2 hearing aids; limits do not apply to one anchored haring aid for eligible dependent children ages 0 - 19	• Non-emergency care when traveling outside the United States • Private-duty nursing (except inpatient private duty nursing)	• Routine eye care (Adult and Children) • Routine foot care (when determined to be medically necessary)

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 Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272). 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 on how 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 the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-800-862-3386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-3386.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-862-3386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-862-3386.

*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)	**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)	**Mia's Simple Fracture** (in-network emergency room visit and follow up care)
■ The **plan's** overall **deductible** $600 ■ **Specialist** $60 ■ Hospital (facility) 10% ■ Other 10%	■ The **plan's** overall **deductible** $600 ■ **Specialist** $60 ■ Hospital (facility) 10% ■ Other 10%	■ The **plan's** overall **deductible** $600 ■ **Specialist** $60 ■ Hospital (facility) 10% ■ Other 10%
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)*	**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)*	**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	**$12,700**

Total Example Cost	**$5,600**

Total Example Cost	**$2,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$60
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,920**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,000
Coinsurance	$100
What isn't covered	
Limits or exclusions	$1,400
The total Joe would pay is	**$3,100**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

* For more information about limitations and exceptions, see the **plan** or policy document at www.fundoffice.org or call 1-800-862-3386.