



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](http://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](http://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 <a href="#">deductible</a> ?                                | \$600/individual*<br>\$1,200/family*<br><i>*Based on calendar year</i>                                                                                                                                                                                       | Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , 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 <a href="#">deductible</a> . If you participate in the <a href="#">plan</a> 's HRA, the HRA will pay for or reimburse you for certain, qualified medical expenses as determined by IRS Section 213(d) for amounts not paid by any other health care coverage, up to the balance available in your HRA. You must be eligible for Plan coverage on the date of service to be eligible for reimbursement. |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventative Care</a> and Chiropractic services are covered before you meet your <a href="#">deductible</a> .                                                                                                                               | This <a href="#">plan</a> covers some items and services even if you haven't met the annual <a href="#">deductible</a> amount. But a <a href="#">copayment</a> , or <a href="#">coinsurance</a> , may apply. For example, this plan covers certain <a href="#">preventative services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventative services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                                                                        |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                                                                                           | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In-Network Medical:<br>\$3,000/individual or family*<br>Out-of-Network Medical:<br>\$5,000/individual or family*<br>In-Network Prescription:<br>2026: \$7,600/individual or family*<br>2027: \$9,000/individual or family*<br><i>*Based on calendar year</i> | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they may have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| Important Questions                                                          | Answers                                                                                                                                                                                                                                                                                                                                             | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is not included in the <a href="#">out-of-pocket limit</a> ?            | <a href="#">Co-payments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billed</a> charges, non-PPO <a href="#">co-insurance</a> , penalties for failure to obtain <a href="#">preauthorization</a> for services, hearing aid PPO <a href="#">co-insurance</a> , and health care this <a href="#">plan</a> does not cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. Visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .                                                                                                                                                                                                              | This <a href="#">plan</a> uses a provider network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No                                                                                                                                                                                                                                                                                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness                           | \$25 <a href="#">copay</a> /office visit     | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                              |
|                                                                        | <a href="#">Specialist</a> visit                                           | \$60 <a href="#">copay</a> /office visit     | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                              |
|                                                                        | <a href="#">Preventive care</a> , <a href="#">screening</a> , immunization | No charge                                    | 20% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventative services</a> . Ask your provider if the services needed are <a href="#">preventative services</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                        | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                              |
|                                                                        | Imaging (CT/PET scans, MRIs)                                               | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                              |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fundoffice.org](http://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<br>(You will pay the least)                                                                                                                                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a><br><br>Customer Service: 1-800-566-5693<br>Mail Order: 1-800-966-5772<br>Specialty Connect: 1-800-237-2767 | Generic drugs                                  | <b>30-day:</b> \$10<br><b>90-day:</b> \$20                                                                                                                                                                                                              | Not Covered                                        | <b>Maintenance Drugs:</b> Prescriptions for maintenance drugs must be filled as 90-day prescription at either at a CVS Pharmacy or by CVS Mail Order.<br><br><b>Non-Maintenance Drugs or Controlled Substances:</b> 30-day supply can be filled at any in-network pharmacy.<br><br>A penalty may apply if a brand drug is requested when a generic is available.<br><br><b>Specialty drugs</b> must be filled through CVS Specialty. <b>Note:</b> Some <b>Specialty drugs</b> may be covered at a \$0 copay through Prudent Rx. You will be contacted by Prudent Rx if this applies to your prescription.<br><br>\$15,000 lifetime maximum on Infertility drugs. |
|                                                                                                                                                                                                                                                                                                                    | Preferred brand drugs                          | <b>30-day:</b> 25%; \$30 min/\$50 max<br><b>90-day:</b> 25%; \$60 min/\$100 max                                                                                                                                                                         | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                    | Non-preferred brand drugs                      | <b>30-day:</b> 30%; \$50 min/\$100 max<br><b>90-day:</b> 30%; \$100 min/\$200 max                                                                                                                                                                       | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                    | <b>Specialty drugs</b>                         | <b>Preferred Brand Specialty:</b><br><b>30-day:</b> 25%; \$30 min/\$50 max<br><b>90-day:</b> 25%; \$60 min/\$100 max<br><br><b>Non-Preferred Brand Specialty:</b><br><b>30-day:</b> 30%; \$50 min /\$100 max<br><b>90-day:</b> 30%; \$100 min/\$200 max | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center) | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                    | Physician/surgeon fees                         | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                     | <b>Emergency room care</b>                     | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                         | 10% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                    | <b>Emergency medical transportation</b>        | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                    | <b>Urgent care</b>                             | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                                                                                 | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions*, & Other Important Information                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                      |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you have a hospital stay</b><br>For further information, call BCBSIL Medical Service Advisory at 1-800-635-1928.               | Facility fee (e.g., hospital room)        | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | <b>Preauthorization</b> required at least 3 days prior to non-emergency admission or within 48 hours of emergency admission. Failure to obtain <b>preauthorization</b> for <b>out-of-network</b> services may result in a \$200 penalty.<br><b>Childbirth:</b> <b>Preauthorization</b> required for hospital stays that exceed 48 hours /vaginal delivery; 96 hours/c-section. |
|                                                                                                                                      | Physician/surgeon fees                    | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need mental health, behavioral health, or substance abuse services</b><br>Call BCBSIL Behavioral Health at 1-800-851-7498. | Outpatient services                       | \$25 <a href="#">copay</a> /office visit     | 20% <a href="#">coinsurance</a>                    | <b>Preauthorization</b> required at least 3 days prior to non-emergency inpatient admission or within 48 hours of emergency admission. Failure to obtain <b>preauthorization</b> for <b>out-of-network</b> services may result in a \$200 penalty. Contact BCBSIL prior to inpatient mental health or substance abuse care.                                                    |
|                                                                                                                                      | Inpatient services                        | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you are pregnant</b>                                                                                                           | Office visits                             | \$25 <a href="#">copay</a> /office visit     | 20% <a href="#">coinsurance</a>                    | <b>Copay</b> applies to first prenatal visit/pregnancy only. Cost sharing does not apply for <b>preventative services</b> . Depending on the type of service, <b>deductible</b> and <b>coinsurance</b> may apply. Maternity care may include tests and services described elsewhere in the SBC.                                                                                |
|                                                                                                                                      | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                      | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                                                                                                 | Services You May Need                     | What You Will Pay                                                        |                                                                                  | Limitations, Exceptions*, & Other Important Information                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                      |                                           | Network Provider<br>(You will pay the least)                             | Out-of-Network Provider<br>(You will pay the most)                               |                                                                                                                                                                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special health needs                                                       | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  | Medical review required.                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                      | <a href="#">Rehabilitation services</a>   | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  | 30 visit limit/diagnosis/benefit period. Includes physical, speech, and occupational therapy. Additional services over maximum require medical review.                                                                                                                                                                                                                                            |
|                                                                                                                      | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  |                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                      | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  | Medical review required.                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                      | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  | Benefits are limited to items used to serve a medical purpose. Some <a href="#">durable medical equipment (DME)</a> may require medical review.                                                                                                                                                                                                                                                   |
|                                                                                                                      | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                                                  | Medical review required. Life expectancy must be 6 months or less.                                                                                                                                                                                                                                                                                                                                |
| If your child needs dental or eye care<br><br>VSP Vision:<br>1-800-877-7195<br><br>BCBSIL Dental:<br>1-800-862-3386. | Children's eye exam                       | No charge for ages 0 – 18<br>\$30 <a href="#">copay</a> for ages 19 - 26 | \$30 <a href="#">copay</a>                                                       | <a href="#">Out-of-Network</a> : Child ages 19-26, <a href="#">Plan</a> will reimburse up to \$45 on one exam per year after the <a href="#">copay</a> is satisfied.                                                                                                                                                                                                                              |
|                                                                                                                      | Children's glasses                        | \$20 <a href="#">copay</a>                                               | \$20 <a href="#">copay</a> +<br>20% <a href="#">coinsurance</a> for<br>ages 0-18 | Child must be an Eligible Dependent.<br><a href="#">In-Network</a> : 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.<br><a href="#">Out-of-Network</a> : Children ages 19-26 reimbursement up to specified limits depending on the type of lens/frame. |
|                                                                                                                      | Children's dental check-up                | No charge                                                                | No charge unless exceeds U&C charges                                             | Child must be an Eligible Dependent.<br><b>Child ages 0-18: <a href="#">Preventative services</a></b> do not apply to dental maximum.<br><b>Child ages 19-26: <a href="#">Preventative services</a></b> do apply to dental maximum.                                                                                                                                                               |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fundoffice.org](http://www.fundoffice.org) or call 1-800-862-3386.

## Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>Bariatric surgery (<i>except in cases of morbid obesity</i>)</li><li>Cosmetic surgery (<i>unless surgery corrects the effect of an injury, congenital deformity or deformity resulting from disease or is determined to be medically necessary</i>)</li></ul>                                                                                                                                                                                                | <ul style="list-style-type: none"><li>Long-term care</li></ul>                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"><li>Weight loss programs (<i>except in the cases of morbid obesity</i>)</li></ul>                                                       |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                           |
| <ul style="list-style-type: none"><li>Acupuncture (<i>30 visit limit/calendar year</i>)</li><li>Chiropractic care (<i>30 visit limit/calendar year, unless determined to be medically necessary</i>)</li><li>Dental Care (<i>Adult and Children</i>)</li><li>Hearing aids (<i>\$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 bone anchored hearing aid for eligible dependent children ages 0 – 19</i>)</li></ul> | <ul style="list-style-type: none"><li>Infertility treatment (<i>Separate \$15,000 lifetime maximum on both infertility drugs and infertility medical treatment</i>)</li><li>Non-emergency care when traveling outside the United States</li><li>Private-duty nursing (<i>except inpatient private duty nursing</i>)</li></ul> | <ul style="list-style-type: none"><li>Routine eye care (<i>Adult and Children</i>)</li><li>Routine foot care (<i>when determined to be medically necessary</i>)</li></ul> |

**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 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](http://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](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-862-3386.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fundoffice.org](http://www.fundoffice.org) or call 1-800-862-3386.



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$600 |
| ■ <a href="#">Specialist</a>                                    | \$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*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$1,200        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,920</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$600 |
| ■ <a href="#">Specialist</a>                                    | \$60  |
| ■ Hospital (facility)                                           | 10%   |
| ■ Other                                                         | 10%   |

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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$1,400        |
| <b>The total Joe would pay is</b> | <b>\$3,100</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$600 |
| ■ <a href="#">Specialist</a>                                    | \$60  |
| ■ Hospital (facility)                                           | 10%   |
| ■ Other                                                         | 10%   |

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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |

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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

**Note:** If you participate in the [Plan's](#) HRA, the HRA will pay for or reimburse you for certain, qualified medical expenses as determined by Internal Revenue Code Section 213(d) for amounts not paid by any other health care coverage up to the balance available in your HRA. You must be eligible for [Plan](#) coverage on the date of service to be eligible for reimbursement.