



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 ?	In-Network: \$1,200/individual*; \$2,400/family* Out-of-Network: \$2,400/individual*; \$4,800/family* <i>*Based on calendar year</i>	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: \$4,000/individual*; \$8,000/family* Out-of-Network Medical: \$8,000/individual* or \$16,800/family* In-Network Prescription: 2026: \$6,150/individual; \$12,300/family* 2027: \$8,000/individual; \$16,000/family* <i>*Based on calendar year</i>	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 care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

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

Important Questions	Answers	Why This Matters:
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	40% coinsurance	None
	Specialist visit	\$60 copay /office visit	40% coinsurance	None
	Preventive care, screening, immunization	No charge	40% 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)	15% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	None

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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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com Customer Service: 1-800-566-5693 Mail Order: 1-800-966-5772 Specialty Connect: 1-800-237-2767	Generic drugs	30-day: \$10 90-day: \$20	Not Covered	Maintenance Drugs: Prescriptions for maintenance drugs must be filled as 90-day prescription at either at a CVS Pharmacy or by CVS Mail Order. Non-Maintenance Drugs or Controlled Substances: 30-day supply can be filled at any in-network pharmacy. A penalty may apply if a brand drug is requested when a generic is available. Specialty drugs must be filled through CVS Specialty. Note: Some Specialty drugs may be covered at a \$0 copay through Prudent Rx. You will be contacted by Prudent Rx if this applies to your prescription. \$15,000 lifetime maximum on Infertility drugs.
	Preferred brand drugs	30-day: 25%; \$35 min/\$100 max 90-day: 25%; \$70 min/\$100 max	Not Covered	
	Non-preferred brand drugs	30-day: 30%; \$55 min/\$100 max 90-day: 30%; \$110 min/\$200 max	Not Covered	
	Specialty drugs*	Preferred Brand Specialty: 30-day: 25%; \$35 min/\$50 max 90-day: 25%; \$70 min/\$100 max Non-Preferred Brand Specialty: 30-day: 30%; \$50 min /\$100 max 90-day: 30%; \$100 min/\$200 max	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	None
	Emergency medical transportation	20% coinsurance	40% coinsurance	You pay 20% coinsurance for out-of-network emergency air ambulance
	Urgent care	15% coinsurance	40% coinsurance	None

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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 have a hospital stay For further information, call BCBSIL Medical Service Advisory at 1-800-635-1928.	Facility fee (e.g., hospital room)	15% coinsurance	40% 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.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services Call BCBSIL Behavioral Health at 1-800-851-7498.	Outpatient services	\$25 copay /office visit	40% 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. Contact BCBSIL prior to inpatient mental health or substance abuse care.
	Inpatient services	15% coinsurance	40% coinsurance	
If you are pregnant	Office visits	\$25 copay /office visit	40% 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	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	

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 need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Medical review required.
	Rehabilitation services	15% coinsurance	40% coinsurance	30 visit limit/diagnosis/benefit period. Includes physical, speech, and occupational therapy. Additional services over maximum require medical review.
	Habilitation services	15% coinsurance	40% coinsurance	
	Skilled nursing care	15% coinsurance	40% coinsurance	Medical review required.
	Durable medical equipment	15% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Some durable medical equipment (DME) may require medical review.
	Hospice services	15% coinsurance	40% coinsurance	Medical review required. Life expectancy must be 6 months or less.
If your child needs dental or eye care VSP Vision: 1-800-877-7195 BCBSIL Dental: 1-800-862-3386.	Children's eye exam	No charge for ages 0 – 18 \$30 copay for ages 19 - 26	\$30 copay	Out-of-Network : Children ages 19-26, Plan will reimburse up to \$45 on one exam per year after the copay is satisfied.
	Children's glasses	\$20 copay	\$20 copay + 20% coinsurance for ages 0 - 18	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.
	Children's dental check-up	No charge	No charge unless exceeds U&C charges	Child ages 0-18: Preventative services do not apply to dental maximum. Child ages 19-26: Preventative services do apply to dental maximum.

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 it corrects the effect of an injury, congenital deformity or deformity resulting from disease or is determined to be medically necessary*)
- 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, unless determined to be medically necessary*)
- Dental Care (*Adult and Children*)
- Hearing aids (*\$75 exam, 80% of first \$500 U&C charges per ear, \$400 maximum benefit/calendar year*); *limits do not apply to bone anchored hearing aid for eligible dependent children ages 0 – 19*)
- Infertility treatment (*Separate \$15,000 lifetime limit on both infertility drugs and infertility medical treatment*)
- 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 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, kwijijgo 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 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 plan's overall deductible	\$1,200
■ Specialist	\$60
■ Hospital (facility)	15%
■ Other	15%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$60
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,120

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,200
■ Specialist	\$60
■ Hospital (facility)	15%
■ Other	15%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$1,000
Coinsurance	\$150
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,370

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,200
■ Specialist	\$60
■ Hospital (facility)	15%
■ Other	15%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

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