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* **$1,200**/family* ***Based on 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* **Out-of-Network Medical:** **$5,000**/individual or family* **In-Network Prescription:** 2025: **$6,200**/individual or family* 2026: **$7,150**/individual or family* ***Based on calendar year**	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.

Important Questions	Answers	Why This Matters:
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.
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

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%; $30 min/$50 max **90-day:** 25%; $60 min/$100 max	Not Covered	
	Non-preferred brand drugs	**30-day:** 30%; $50 min/$100 max **90-day:** 30%; $100 min/$200 max	Not Covered	
	Specialty drugs	**Preferred Brand Specialty:** **30-day:** 25%; $30 min/$50 max **90-day:** 25%; $60 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)	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

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)	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.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services Call BCBSIL Behavioral Health at 1-800-851-7498.	Outpatient services	$15 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. Contact BCBSIL prior to inpatient mental health or substance abuse care.
	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.
	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.
	Rehabilitation services	10% coinsurance	20% coinsurance	30 visit limit/diagnosis/benefit period. Includes physical, speech, and occupational therapy. Additional services over maximum require medical review.
	Habilitation services	10% coinsurance	20% 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)	
	Skilled nursing care	10% coinsurance	20% coinsurance	Medical review required.
	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.
	Hospice services	10% coinsurance	20% 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 surgery 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

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 $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)*
- Infertility treatment *(Separate $15,000 lifetime maximum 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, 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)

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)*

Total Example Cost	**$12,700**
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**

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

The plan's overall deductible	$600
Specialist	$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	
Deductibles	$600
Copayments	$1,000
Coinsurance	$100
What isn't covered	
Limits or exclusions	$1,400
The total Joe would pay is	**$3,100**

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%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$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.