



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-630-516-8008. 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.com](http://www.dol.gov/ebsa/healthreform.com) or call 1-630-516-8008 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$200</b> Individual/ <b>\$500</b> Family (January 1 – December 31)	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have any other family members in the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> physicals (employee and spouse only), care for carpal tunnel syndrome (bargained employees only), HPV vaccinations, COVID-19 vaccinations and related services, well-child care, <u>in-network prescription drugs</u> , dental care, and colonoscopy <u>screenings</u> (including Cologuard) are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Medical: <b>\$800</b> Individual/ <b>\$2,500</b> Family; <u>Prescription Drugs:</u> <b>\$1,000</b> Individual (January 1 – December 31)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, the <u>deductible</u> , additional amounts paid for using a non-PPO hospital or facility, dental care, <u>out-of-network</u> organ transplants, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-517-1043 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		PPO Provider (You will pay the least)	Non-PPO 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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge and no <u>deductible</u> applies to COVID-19 related diagnostic visits.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Preventive care/screening/Immunization	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge and no <u>deductible</u> applies to one routine physical <u>preventive care</u> exam (including lab work) per calendar year for employee and spouse only.  No charge and no <u>deductible</u> applies to colonoscopies (age 45+) once every 10 years or as <u>medically necessary</u> or to Cologuard (age 45+) once every 3 years or as <u>medically necessary</u> for employee and dependents.  <u>Deductible</u> does not apply to well-child care or to HPV, pneumonia, and shingles vaccinations.  No charge applies to flu shots from a PPO <u>provider</u> .  No charge and no <u>deductible</u> applies to COVID-19-related vaccinations.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge and no <u>deductible</u> applies to first \$150 of covered expenses per calendar year; then, 20% <u>coinsurance</u> .	No charge and no <u>deductible</u> applies to first \$150 of covered expenses per calendar year; then, 20% <u>coinsurance</u> .	No charge and no <u>deductible</u> apply to COVID-19-related <u>diagnostic tests</u> .
	Imaging (CT/PET scans, MRIs)	No charge and no <u>deductible</u> applies to first \$150 of covered expenses per calendar year; then, 20% <u>coinsurance</u> .	No charge and no <u>deductible</u> applies to first \$150 of covered expenses per calendar year; then, 20% <u>coinsurance</u> .	None

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). <u>Prescription drug out-of-pocket limit</u> : \$1,000 per person per calendar year
	Brand name drugs	50% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	Medications to treat obesity require pre-approval or the drugs may not be covered or an additional letter from your physician may be required.
	Specialty Drugs	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	Medications taken on an ongoing basis must be filled through the mail order program. If a brand name medication is dispensed when a generic is available, you pay 50% of the cost of the brand name medication plus the difference in cost between the generic and brand name medication. <u>Specialty drugs</u> administered through Accredo, Express Scripts' Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Local transportation limited to one trip to and from location for any one sickness or all injuries sustained in one accident.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH). 20% of the amount you pay for non-PPO Hospitals or inpatient facilities counts toward your <u>out-of-pocket limit</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Office visits: 20% <u>coinsurance</u> ; Hospital or facility outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	20% of the amount you pay for non-PPO Hospitals or inpatient facilities counts toward your <u>out-of-pocket limit</u> . Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).  20% of the amount you pay for non-PPO Hospitals or inpatient facilities counts toward your <u>out-of-pocket limit</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires prior <u>hospitalization</u> and physician approval within seven days of confinement.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Outpatient: 20% <u>coinsurance</u> ; Inpatient: 30% <u>coinsurance</u>	Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage includes treatment for autism including ABA therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Outpatient: 20% <u>coinsurance</u> ; Inpatient: 30% <u>coinsurance</u>	Requires prior <u>hospitalization</u> or confinement in a skilled nursing facility and must begin within 3 days of confinement. Continued physician treatment and certification required at least every 14 days.  Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Covered in hospital or in home.

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even from a <u>PPO provider</u> . You may submit vision expenses for reimbursement from your Health Spending Account (maximum reimbursement for all eligible covered medical expenses is \$2,500 per family per calendar year).
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a <u>PPO provider</u> . You may submit vision expenses for reimbursement from your Health Spending Account (maximum reimbursement for all eligible covered medical expenses is \$2,500 per family per calendar year).
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Separately administered by Delta Dental.

## Excluded Services & Other Covered Services:

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery (unless <u>medically necessary</u>)</li><li>• Cosmetic surgery (except if due to injury, a congenital defect, improper organ functioning, or for <u>reconstructive surgery</u> following mastectomy)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (a discount program is available through Epic Hearing)</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult and Child) (except Lasik corrective surgery up to \$4,500 per person per lifetime)</li><li>• Routine foot care</li><li>• Weight loss programs (generally eligible for reimbursement under Health Spending Account if undertaken at a physician's direction to treat an existing condition)</li></ul>

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

<ul style="list-style-type: none"><li>• Chiropractic care (if <u>medically necessary</u>)</li><li>• Dental care (Adult) (\$2,500 maximum per person per calendar year, except for preventive dental services for individuals under age 19)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment (up to \$10,000 per person per lifetime for employees and spouses only)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (if <u>medically necessary</u> when not in a hospital or nursing home)</li></ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: Benefits Office, Tuckpointers Local 52 Health and Welfare Trust, 660 Industrial Drive, Suite 201, Elmhurst, Illinois 60126, 1-630-516-8008. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 1-630-516-8008.

*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 PPO provider pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$610
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$830</b>

### Managing Joe's Type 2 Diabetes

(a year of routine PPO provider care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,140
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,340</b>

### Mia's Simple Fracture

(PPO provider emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$520
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$720</b>

A Health Spending Account is also available under this Plan. This generally covers expenses that qualify as allowable "medical care" by the IRS and satisfy any requirements imposed by the Plan.

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