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 or call 1-630-516-8008 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** Individual/**$500** Family (January 1 – December 31)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have any other family members in the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care physicals (employee and spouse only), care for carpal tunnel syndrome (bargained employees only), HPV vaccinations, COVID-19 vaccinations and related services, well-child care, second or third surgical opinions, in-network prescription drugs, dental care, and colonoscopy screenings (including Cologuard) are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Medical: **$800** Individual/**$2,500** Family; Prescription Drugs: **$1,000** Individual (January 1 – December 31)	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, the deductible, penalties for failure to obtain a second surgical opinion when required, additional amounts paid for using a non-PPO hospital or facility, dental care, out-of-network organ transplants, and health care this plan doesn't 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. See www.bcbsil.com or call 1-800-517-1043 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
		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% coinsurance	20% coinsurance	No charge and no deductible applies to COVID-19 related diagnostic visits.
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ Immunization	20% coinsurance	20% coinsurance	No charge and no deductible applies to one routine physical preventive care exam (including lab work) per calendar year for employee and spouse only. No charge and no deductible applies to colonoscopies (age 45+) once every 10 years or as medically necessary or to Cologuard (age 45+) once every 3 years or as medically necessary for employee and dependents. Deductible does not apply to well-child care or to HPV, pneumonia, and shingles vaccinations. No charge applies to flu shots from a PPO provider. No charge and no deductible applies to COVID-19-related vaccinations.

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 test	Diagnostic test (x-ray, blood work)	No charge and no deductible applies to first $150 of covered expenses per calendar year; then, 20% coinsurance.	No charge and no deductible applies to first $150 of covered expenses per calendar year; then, 20% coinsurance.	No charge and no deductible apply to COVID-19-related diagnostic tests.
	Imaging (CT/PET scans, MRIs)	No charge and no deductible applies to first $150 of covered expenses per calendar year; then, 20% coinsurance.	No charge and no deductible applies to first $150 of covered expenses per calendar year; then, 20% coinsurance.	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	20% coinsurance; deductible does not apply	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). Prescription drug out-of-pocket limit: $1,000 per person per calendar year Medications to treat obesity require pre-approval or the drugs may not be covered or an additional letter from your physician may be required. 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. Specialty drugs administered through Accredo, Express Scripts' Specialty Pharmacy.
	Brand name drugs	50% coinsurance; deductible does not apply	Not covered	
	Specialty Drugs	20% coinsurance; deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	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 need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Local transportation limited to one trip to and from location for any one sickness or all injuries sustained in one accident.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	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 out-of-pocket limit.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	No charge and no deductible applies to second or third surgical opinions. If you do not obtain a second opinion when required under the plan for certain surgeries, your benefits for surgery will be reduced by 20%, and your benefits for the fees charged by the Physician performing the procedure will be reduced to 50%. The additional amounts you would have to pay out-of-pocket do not count towards meeting your annual deductible or out-of-pocket limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Office visits: 20% coinsurance; Hospital or facility outpatient services: 30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	20% of the amount you pay for non-PPO Hospitals or inpatient facilities counts toward your out-of-pocket limit. 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 out-of-pocket limit. Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Requires prior hospitalization and physician approval within seven days of confinement.
	Rehabilitation services	20% coinsurance	Outpatient: 20% coinsurance; Inpatient: 30% coinsurance	Hospitals or inpatient facilities must be licensed and accredited by the Joint Commission (JCAH).
	Habilitation services	20% coinsurance	20% coinsurance	Coverage includes treatment for autism including ABA therapy.
	Skilled nursing care	20% coinsurance	Outpatient: 20% coinsurance; Inpatient: 30% coinsurance	Requires prior hospitalization 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).
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	30% coinsurance	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 PPO provider. 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 PPO provider. 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. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Separately administered by Delta Dental.

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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery (except if due to injury, a congenital defect, improper organ functioning, or for reconstructive surgery following mastectomy)
- Hearing aids (a discount program is available through Epic Hearing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child) (except Lasik corrective surgery up to $4,500 per person per lifetime)
- Routine foot care
- Weight loss programs (generally eligible for reimbursement under Health Spending Account if undertaken at a physician's direction to treat an existing condition)

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

- Chiropractic care (if medically necessary)
- Dental care (Adult) ($2,500 maximum per person per calendar year, except for preventive dental services for individuals under age 19)
- Infertility treatment (up to $10,000 per person per lifetime for employees and spouses only)
- Private-duty nursing (if medically necessary when not in a hospital or nursing home)

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. 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: 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.

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 plan's overall deductible	**$200**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$610
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$830**

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

The plan's overall deductible	**$200**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,140
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,340**

Mia's Simple Fracture
(PPO provider emergency room visit and follow up care)

The plan's overall deductible	**$200**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$520
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$720**

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.*