



FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

DATE: May 1, 2026
TO: Plan Participants
FROM: Board of Trustees

SUBJECT: Fox Valley Laborers Health and Welfare Fund
Summary of Benefits and Coverage

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Enclosed is the Fox Valley Laborers Health and Welfare Fund Summary of Benefits and Coverage (SBC). This document is being provided to you as part of the Affordable Care Act to help participants and their families understand your health coverage, as well as to understand common terms used by the health plan. Receipt of this document does not guarantee eligibility for benefits.

The SBC is provided in a standard format and can only differ regarding specific plan benefits. We hope the document will be a helpful resource by identifying the key provisions of the Fund's health and welfare plan. Due to space considerations, the document does not identify all of the rules governing benefits and coverage. Please continue to refer to the January 2019 Edition of the Summary Plan Description booklet and subsequent Summary of Material Modifications for a complete statement of the Fund's rules governing the benefits and coverage.

The SBC provides three examples of services covered under the plan. These examples help illustrate how deductibles, copays and coinsurance work under the plan. There are three examples provided: having a baby, managing Type 2 diabetes, and treatment of a simple fracture. Because each person's care will be different, these examples are not intended to show exact costs. Instead, the sample costs are based on national averages supplied by the U.S. Department of Health and Human Services and they are not specific to a certain geographic area or health plan.

If you are not clear about any of the underlined terms used in the SBC, you can view the Uniform Glossary. The Uniform Glossary is a separate document from the SBC and is available at <https://www.healthcare.gov/sbc-glossary/> or you can call the Fund Office toll free at (866) 828-0900 to request a copy.

If you have any questions, please do not hesitate to contact the Fund Office.





FOX VALLEY & VICINITY LABORERS

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-696-6775
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.
Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε αγγλικά, οι υπηρεσίες γραμματείας, δωρεάν, είναι διαθέσιμες σε εσάς. Καλέστε 1-877-696-6775.
Gujarati	સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિ:શુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-877-696-6775 પર કોલ કરો
Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं नि:शुल्क, आपके लिए उपलब्ध हैं। 1-877-696-6775 पर कॉल करें।
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-696-6775.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-696-6775.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775.
Urdu	لئے کے آپ، چارج مفت، خدمات یک مدد یک زبان، تو یہ بولتے انگلش آپ اگر: انتباه یہ ابی دست 1-877-696-6775 کو
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775.

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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 1-866-828-0900 or visit us at www.fvlab.com. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-866-828-0900 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$150 per person / \$400 family Carry forward of October, November and/or December expenses satisfying the deductible to the next calendar year</p>	<p>Generally, you must pay all of 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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Certain preventive care, accidental injury and prescription drugs are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care services without cost sharing and before you meet your deductible. See a list of covered preventive care services at www.healthcare.gov/coverage/preventive-care-benefits/</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. Dental: \$50 per person. Doesn't apply to preventive dental care. There are no other specific deductibles.</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Medical: \$1,500 per person, plus \$150 deductible (\$400 family) network providers only. Prescription Drug: \$3,000 per person</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Out-of-network provider charges and care the plan doesn't cover</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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 <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	For accidental injury, <u>Plan</u> pays 100% of covered expenses for office visits, physician services, and hospital charges incurred within 48 hours of the injury; up to \$750 per person per calendar year (<u>deductible</u> waived).
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Acupuncture is covered for individuals over age five for treatment of the back, neck, spine, and vertebra, for conditions due to subluxation, strains, sprains, and nerve root problems. The care must be provided by a physician. Chiropractic care rendered by a licensed chiropractor for individuals over age five for treatment of dysfunction in joints and muscles that may be associated with neurological or mechanical dysfunction of the spinal joint and surrounding tissue and appendicular skeleton for up to 26 visits per calendar year with an extension of up to an additional 26 medically necessary visits after medical review is covered.
	<u>Preventive care/screening/immunization</u>	No charge (<u>deductible</u> does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out-of-pocket limit expenses. **2 of 7**

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)		
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.caremark.com</p>	Preferred brand drugs	<p>Retail - \$8</p> <p>copayment/prescription; Mail Order or Contracted Retail Pharmacy - \$15</p> <p>copayment/prescription</p>	<p>Retail – 50% coinsurance after \$8 copayment/prescription; if no in-network pharmacy available within zip code, 20% coinsurance after \$8 copayment/prescription. File claim with Fund Office</p>	<p>Covers up to 30-day supply (retail); 90-day supply (mail order or contracted retail pharmacy). 90-day supply is required for maintenance medications after two 30-day retail pharmacy fills.</p> <p>Copayments count towards the prescription drug out-of-pocket limit. Your specialty drug copayment does not count towards the prescription drug out-of-pocket limit if the drug is on the PrudentRx drug list and you don't enroll in the program.</p> <p>Certain preventive medications including certain contraceptives and immunizations are covered at no charge at a network pharmacy. Certain prescriptions are not covered, including prescriptions that are not on the pharmacy network formulary list.</p> <p>Certain drugs require prior authorization. If you don't get prior authorization, benefits could be reduced where plan pays nothing. Clinical management programs apply to certain prescription drugs, including specialty medications.</p> <p>Specialty drugs must be dispensed by the CVS/Caremark specialty pharmacy.</p>	
		Non-preferred brand drugs	Same as preferred		Same as preferred
		<p>Specialty drugs</p>	<p>Same as preferred if drug is not on the PrudentRx drug list; if the drug is on the PrudentRx drug list and member enrolls - \$0 copayment/prescription; if not enrolled - 30% coinsurance</p>		Not covered
<p>If you have outpatient surgery</p>	<p>Facility fee (e.g., ambulatory surgery center)</p>	10% coinsurance	30% coinsurance	<p>Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.</p>	
	Physician/surgeon fees	10% coinsurance	30% coinsurance		

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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 immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	If accidental injury care received within 48 hours of the injury, deductible does not apply and coinsurance does not apply to the first \$750 of charges. Air transportation is covered only if due to inaccessibility by ground transport or ground transport would be detrimental to the patient's health status. If accidental injury care received within 48 hours of the injury, deductible does not apply and coinsurance does not apply to the first \$750 of charges.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Private rooms are only covered if it is determined to be medically necessary ; weekend admission (Friday or Saturday) is covered only if treatment or surgery is provided within 24 hours of hospital admission. Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance. Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance. Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Inpatient services	10% coinsurance	30% coinsurance	
	Office visits	10% coinsurance	30% coinsurance	
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have	Home health care	10% coinsurance	30% coinsurance	Covered for care within seven days following an inpatient hospital stay for the same or

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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)	
other special health needs				related condition
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical, speech and occupational therapy for short-term therapy for physical treatment to improve the status of a physical disability and ordered by a physician is covered for a continuous course of treatment for up to 26 weeks (short-term) for a specific condition/diagnosis when performed by a registered physical therapist or chiropractor, registered speech therapist, or registered or licensed occupational therapist. An extension of benefits recommended by the physician may be approved after medical review in certain specific circumstances. Refer to the plan document for additional rules and limitations.
	Habituation services	10% coinsurance	30% coinsurance	Physical, speech and occupational therapy is covered for dependents with a congenital disability.
	Skilled nursing care	10% coinsurance	30% coinsurance	Must be provided by a licensed registered or practical nurse and prescribed by a physician.
	Durable medical equipment	10% coinsurance . Covers the rental of durable medical equipment not to exceed a reasonable purchase price	30% coinsurance . Covers the rental of durable medical equipment not to exceed a reasonable purchase price.	Purchase of medically necessary equipment and cost of maintenance agreements are covered only when the plan determines that it is cost effective. One pair of medically necessary custom orthotic devices prescribed by a physician or podiatrist is covered in a 12-month period.
If your child needs dental or eye care	Hospice services	10% coinsurance	30% coinsurance	Coverage limited to an individual who is diagnosed as terminally ill with 6 months or less to live by a certified physician.
	Children's eye exam	No charge (deductible does not apply)	No charge (deductible does not apply)	Once every calendar year
	Children's glasses	No charge	No charge	\$300 calendar year limit.

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses.

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)	
	Children's dental check-up	Preventive Care - No charge (<u>deductible</u> does not apply) General Care – 15% coinsurance (dental <u>deductible</u> applies)	Preventive Care - No charge (<u>deductible</u> does not apply) General Care – 15% coinsurance (dental <u>deductible</u> applies)	Dental x-rays fall under General Care. Annual limit for children: up to age 18 – no annual limit age 18 and over – \$2,500 limit

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.)

- Cosmetic surgery (limited exceptions)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs and weight loss drugs

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

- Acupuncture
- Bariatric surgery (authorization required)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment (excluding children)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (transplant care)
- Routine eye care (Adult)

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: Department of Labor's 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](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, you can contact: the Fund Administrative Office at 1-866-828-0900 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <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 1-866-828-0900.

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, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses. **6 of 7**

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. For more information you can access a cost estimator tool at [My Cost Estimates](#).

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$150
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

[Specialist office visits \(pre-natal care\)](#)
[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	\$150
Copayments	\$10
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,420

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$150
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other (Rx) copayments \$8/\$15/Rx

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	\$150
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$670

Mia's Simple Fracture

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

- The plan's overall deductible \$150
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

[Emergency room care \(including medical supplies\)](#)
[Diagnostic tests \(x-ray\)](#)
[Durable medical equipment \(crutches\)](#)
[Rehabilitation services \(physical therapy\)](#)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$10
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$460

A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out-of-pocket limit expenses

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

