



FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

DATE: May 1, 2017
TO: Employers and Participants
FROM: Board of Trustees
SUBJECT: Fox Valley Laborers Health and Welfare Fund
Summary of Benefits and Coverage

BOARD OF TRUSTEES WELFARE FUND

Management:

Michael Shales, Chairman

John P. Bryan

Al Orosz

Union:

Corey R. Johnson, Secretary

Vernon Bauman

David B. Sheahan

PENSION FUND

Management:

Michael Shales, Chairman

John P. Bryan

Al Orosz

Union:

Vernon Bauman, Secretary

Martin D. Dwyer

Corey R. Johnson

Enclosed is the Fox Valley Laborers Health and Welfare Fund Summary of Benefits and Coverage. This document is being provided to you as part of the Affordable Care Act to help employers, 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 Summary Plan Description 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 treating 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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> 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

HEALTH AND WELFARE AND PENSION FUNDS

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.

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。

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.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.

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.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-696-6775.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-696-6775.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-696-6775.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-696-6775.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-877-696-6775 まで、お電話にてご連絡ください。

لكت توافر ال لغوية الامساعدة خدمات ف إن ال لغة، انكرت تحدث ك نت إذ: ملحوظة
8776966775: وال بكم ال صم هاتف . رقم) 8776966775 ب رقم ات صل ب الامجان

BOARD OF TRUSTEES

WELFARE FUND

Management:

Michael Shales, Chairman

John P. Bryan

Al Orosz

Union:

Corey R. Johnson, Secretary

Vernon Bauman

David B. Sheahan

PENSION FUND

Management:

Michael Shales, Chairman

John P. Bryan

Al Orosz

Union:

Vernon Bauman, Secretary

Martin D. Dwyer

Corey R. Johnson



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:
What is the overall deductible ?	\$150 person / \$400 family Carry forward of October, November and/or December expenses satisfying the deductible to the next calendar year	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 .
Are there services covered before you meet your deductible ?	Yes. Certain preventive care and prescription drugs 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?	Yes. Dental: \$50 person. Doesn't apply to preventive dental care . There are no other specific deductibles .	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.
What is the out-of-pocket limit for this plan ?	Medical: \$1,500 person, plus \$150 deductible	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit ?	Balance-billing charges, health care this plan doesn't cover and prescription drug copayments	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 1-800-810-2583 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	10% coinsurance	20% coinsurance	For accidental injury, Plan 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 (deductible waived).
	Specialist visit	10% coinsurance	20% coinsurance	Chiropractic care and 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.
	Preventive care/screening/immunization	No charge (deductible waived)	No charge (deductible waived)	Provider must be a physician. Employee and spouse routine exams and immunizations are covered. Immunizations at a pharmacy or retail clinic are covered. Dependent children routine exams and immunizations are not covered unless mandated by the Board of Education for school or school related athletic participation.
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	Generic drugs	Retail - \$8 copayment /prescription; Mail Order - \$15 copayment /prescription	Retail – 50% coinsurance after \$8 copayment /prescription; if no in-network pharmacy available within zip code, 20% coinsurance after \$8 copayment /prescription	Covers up to 30-day supply (retail); 90-day supply (mail order). Mail order is required for maintenance medications after two pharmacy fills. Certain prescriptions are not covered, including prescriptions that are not on the pharmacy network formulary list. Certain drugs require prior authorization . Clinical management programs apply to certain prescription drugs, including specialty medications . Specialty drugs must be dispensed by the CVS/Caremark specialty pharmacy.
	Preferred brand drugs	Retail - \$15 copayment /prescription; Mail Order - \$30 copayment /prescription; And, if generic is available copayment is \$15 or \$30 plus the cost differential between the brand name and generic drug.	Retail – 50% coinsurance after \$15 copayment /prescription; if no in-network pharmacy available within zip code, 20% coinsurance after \$15 copayment /prescription	
	Non-preferred brand drugs	Same as preferred	Same as preferred	
	Specialty drugs	Same as preferred	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	20% 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.
	Emergency medical transportation	10% coinsurance	20% coinsurance	Air transportation is covered only if due to inaccessibility by ground transport or ground transport would be detrimental to the patient's health status.
	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	Facility fee (e.g., hospital room)	10% coinsurance	20% 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.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	Inpatient facility must meet Plan requirements. Mental/Behavioral health covered if provided by a licensed psychiatrist or Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); or, a clinical psychologist, licensed clinical professional counselor, or licensed social worker only when prescribed by and under the ongoing supervision of a licensed psychiatrist or M.D or D.O.
	Inpatient services	10% coinsurance	20% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	Physical and occupational therapy is covered for a continuous course of treatment for up to 26 weeks (short-term) for a specific condition when performed by a registered physical therapist and licensed occupational therapist. Physical therapy is not covered if performed by a chiropractor. Chiropractic care is not covered if received at the same time as physical therapy. Extension of benefits can be approved in 4 week increments up to 52 weeks if due to an accidental injury resulting in hospitalization. Speech therapy is covered if it's to restore speech as a result of an accidental injury or illness or to restore speech in individuals who are unable to speak as a result of a hearing

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)	
				disorder. Speech therapy is only covered if performed by a licensed speech therapist.
	Habilitation services	10% coinsurance	20% coinsurance	Physical and occupational therapy is covered for dependents with congenital disability.
	Skilled nursing care	10% coinsurance	20% 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	20% 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.
	Hospice services	10% coinsurance	20% coinsurance	Coverage limited to an individual who is diagnosed as terminally ill with 6 months or less to live by a certified physician.
If your child needs dental or eye care	Children's eye exam	No charge (deductible waived)	No charge (deductible waived)	None
	Children's glasses	No charge	No charge	\$300 calendar year limit.
	Children's dental check-up	Preventive Care - No charge (deductible waived) General Care – 15% coinsurance (dental deductible applies)	Preventive Care - No charge (deductible waived) General Care – 15% coinsurance (dental deductible applies)	Dental x-rays fall under General Care. Annual limit for children: up to age 18 – no annual limit age 18 and over – \$1,500 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) | • Private-duty nursing | • Weight loss programs |
| • Long-term care | • Routine foot care | |

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

- | | | |
|--|--|--|
| • Acupuncture | • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery (authorization required) | • Hearing aids | • Private-duty nursing (transplant care) |
| • Chiropractic care | • Infertility treatment (excluding children) | • 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. For more information on your rights to continue coverage, contact the plan at 1-866-828-0900. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa>. 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 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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	\$150
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$30
Coinsurance	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,490

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 coinsurance	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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$440
Coinsurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$930

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 test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$250