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 1-708-449-7373. 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.http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.com or call 1-708-449-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. For retirees and spouses under the Plan's Wellness Benefit.	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, retirees and spouses are entitled to certain routine services to maintain wellness under the plan's Wellness Benefit, which covers certain services without deductibles or copayments.
Are there other deductibles for specific services?	Yes. **$50** for dental benefits per person and **$50** for prescription drugs per person. 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?	**$2,000** per person for prescription drugs.	The out-of-pocket limit is the most you could pay during the coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing, health care services this plan does not cover, and deductibles.	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. For a list of participating providers, visit deltadentalil.com, call 1-800 323-1743 or call the Fund Office at 1-708-449-7373.	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	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Specialist visit	Not covered.	Not covered.	
	Preventive care/screening/ immunization	Not covered.	Not covered.	Retiree and spouse have wellness benefit covering certain services at 100% (no deductible or coinsurance).
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Imaging (CT/PET scans, MRIs)	Not covered.	Not covered.	
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	30% coinsurance (Retail) 30% coinsurance (Mail)	Not covered.	Retail prescription covers up to 34-90 day supply; mail order prescription covers up to 31-90 day supply. Non-PPO (non-participating pharmacy) purchases are not covered, except in limited circumstances.
	Brand drugs (when no generic is available)	30% coinsurance (Retail) 30% coinsurance (Mail)	Not covered.	
	Brand drugs (when generic is available)	30% coinsurance (Retail) 30% coinsurance (Mail)	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Physician/surgeon fees	Not covered.	Not covered.	
If you need immediate medical attention	Emergency room care	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Emergency medical transportation	Not covered.	Not covered.	
	Urgent care	Not covered.	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.

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)	
	Physician/surgeon fees	Not covered.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Inpatient services	Not covered.	Not covered.	
If you are pregnant	Office visits	Not covered.	Not covered.	Not covered.
	Childbirth/delivery professional services	Not covered.	Not covered.	
	Childbirth/delivery facility services	Not covered.	Not covered.	
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	Services under Hospice Care Program covered 100%.
	Rehabilitation services	Not covered.	Not covered.	
	Habilitation services	Not covered.	Not covered.	
	Skilled nursing care	Not covered.	Not covered.	
	Durable medical equipment	Not covered.	Not covered.	
	Hospice services	No charge.	No charge.	No deductible or coinsurance applies. 16-day limit for inpatient and 80-day limit for outpatient. Maximum benefit of $10,000 per person.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge up to $50	Not subject to deductible.
	Children's glasses	No charge up to $425 during consecutive two-year period; 20% off balance over $425	No charge up to $250	Not subject to deductible.
	Children's dental check-up	No charge.	Not charge.	Preventive services at 20% coinsurance. Basic services 40% coinsurance. Major services 60%

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)	
				coinsurance. Dental anesthesia 60% coinsurance. $50 deductible per year per person applies. Benefit limited to $1,500 per year per person.

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
- Chiropractor Care
- Cosmetic Surgery
- Gene Therapy Treatments and Gene Therapy Prescription Drugs
- Habilitation Services
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Speech therapy
- Weight loss programs
- Orthodontics

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

- Dental care (adult)
- Hearing Aids (up to $1,250 per device)
- 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: the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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, contact the Fund Office at 1-708-449-7373. Additionally, assistance may be provided by your local EBSA office by calling 1-866-444-3272.

Does this plan provide Minimum Essential Coverage? No

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? **No**
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 1-708-449-2122.

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 in-network coverage.**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$0**
■ **Specialist coinsurance**	**100%**
■ **Hospital (facility) coinsurance**	**100%**
■ **Other coinsurance**	**100%**

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*	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,710**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist coinsurance**	**100%**
■ **Hospital (facility) coinsurance**	**100%**
■ **Other coinsurance**	**30%**

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*	$50
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$2,100
The total Joe would pay is	**$3,150**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$0**
■ **Specialist coinsurance**	**100%**
■ **Hospital (facility) coinsurance**	**100%**
■ **Other coinsurance**	**100%**

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	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,810**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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