



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, visit www.csjunion.org/healthandwelfare or call 1-312-738-0822. 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.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers and out-of-area providers : \$1,000 per person/ \$3,000 per family per calendar year; for out-of-network providers : Not applicable.	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, in-network preventive care and wellness benefits 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
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?	For in-network providers and out-of-area providers : \$3,800 per person/ \$11,400 per family per calendar year; for out-of-network providers : Not applicable.	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 , 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?	Penalties for failure to obtain pre-authorization, premiums , balance-billing charges, 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. For a list of preferred providers , see www.bcbsil.com or call 1-888-810-BLUE (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 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	\$25 copayment /office visit	Not Covered	-----None-----
	Specialist visit	\$50 copayment /office visit	Not Covered	Chiropractic services subject to 20% coinsurance and limited to \$500 per year.
	Preventive care/screening/immunization	No Charge (Deductible does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of covered preventive services at: www.healthcare.gov/coverage/preventive-care-benefits/ .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	-----None-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rxsolutions.com	Retail (30-day supply) or Mail (90-day supply)			
	Generic drugs	10% coinsurance , with a \$200 maximum per prescription	Not Covered	
	Brand drugs	35% coinsurance , with a \$200 maximum per prescription	Not Covered	\$6,350 per person/\$8,900 per family in-network out-of-pocket limit per calendar year.
	Brand drugs when Generic is available	35% coinsurance , with a \$200 maximum per prescription, plus 100% of the difference in cost of the generic and brand name medication	Not Covered	Maintenance drugs must be filled through the OptumRx Mail Service Pharmacy, which covers up to a 90-day supply.
	Specialty drugs	20% coinsurance , with a \$250 maximum per prescription	Not Covered	

* For more information about limitations and exceptions, see the plan document at www.csjunion.org or call 1-312-738-0822.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>		Certain types of surgeries must be performed on an outpatient basis. Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$400 <u>copayment</u> per emergency room visit		<u>Copayment</u> waived if admitted to Hospital within 48 hours of treatment.
	Emergency medical transportation	20% <u>coinsurance</u>	Not Covered except air ambulances covered at 20% coinsurance	Coverage limited to first trip to and/or from Hospital for any one sickness or for all injuries resulting from any one accident.
	Urgent care	\$25 <u>copayment</u>	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>		Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>		Pre-certification required for inpatient and outpatient services; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . Pre-certification requirement does not apply to office visits.
	Inpatient services			
If you are pregnant	Office visits	20% <u>coinsurance</u>		Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> . <u>Preventive services</u> are covered at no cost.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . Limited to 60 visits per calendar year. If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> and are limited to 40 visits per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .

	Habilitation services	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Skilled nursing care	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
	Durable medical equipment	20% <u>coinsurance</u>	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> .
	Hospice services	20% <u>coinsurance</u> if arranged through Case Management Services	Not Covered	Pre-certification required; otherwise, you must pay a \$500 penalty, which does not count toward your <u>deductible</u> or <u>out-of-pocket limit</u> . If not arranged through Case Management Services, you must pay 30% <u>coinsurance</u> .
If your child needs dental or eye care	Children's eye exam		Not Covered	Vision screening for children is covered as a <u>preventive service</u> with no charge.
	Children's glasses			
	Children's dental check-up			

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
- Cosmetic surgery (unless performed to correct congenital defect, defects incurred through traumatic injury, or malfunctioning organs)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the United States
- Private duty nursing
- Routine eye care (Adult)

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

- Bariatric surgery
- Chiropractic care (\$500 calendar year maximum)
- Infertility treatment (\$5,000 lifetime maximum; Employee and eligible Spouse only)
- Routine foot care
- Weight loss program (if 100% over medically desired weight; threat to life; and medical history of unsuccessful attempt to lose weight by other methods)

* For more information about limitations and exceptions, see the plan document at www.csjunion.org or call 1-312-738-0822.

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-EBSA (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 the Plan at 1-312-738-0822. 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. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at 1-877-527-9431 or <http://insurance.illinois.gov/>.

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 1-312-738-0822.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-312-738-0822 uff.

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	\$1,000
■ Specialist copayment	\$50
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$50
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$300
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$50
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$600
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Important Notice from Central States Joint Board Health & Welfare Trust Fund About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Central States Joint Board Health and Welfare Trust Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Central States Joint Board Health and Welfare Trust Fund has determined that the prescription drug coverage offered by the Central States Joint Board Health and Welfare Trust Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to enroll in a Medicare prescription drug plan and drop your Central States Joint Board Health and Welfare Trust Fund prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Currently, the Central States Joint Board Health & Welfare Fund offers the following prescription drug coverage:

Generic:	10% copay up to a maximum of \$200
Brand:	35% copay up to a maximum of \$200 if no generic is available; or 35% copay and 100% of the difference in cost between the generic and brand name medication up to a maximum of \$200 if a generic is available.
Specialty:	20% copay up to a maximum of \$250
Deductible:	None
Out of Pocket Maximum:	Overall; \$6,350 Single / \$8,900 Family

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll

in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Central States Joint Board Health and Welfare Trust Fund and don't enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information about This Notice Or Your Current Prescription Drug Coverage...

Contact our office for further information at (312) 738-0822. NOTE: You'll get this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: August 25, 2025

Name of Entity/Sender: Central States Joint Board Health & Welfare Fund
Contact – Position/Office: Fund Office
Address: 245 Fencel Lane, Hillside, IL 60162-2001
Phone Number: (312) 738-0822

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).