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, contact the Fund office, 773-254-2500. 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 in the SPD or call 773-254-2500

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/Individual or $900/Family	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 his or her own deductible, to a max of three deductibles per family.
Are there services covered before you meet your deductible?	Yes, most Preventive care is covered before you meet your deductible.	This plan covers certain preventive services without cost sharing and before you meet your deductible.
Are there other deductibles for specific services?	No	
What is the out-of-pocket limit for this plan?	$2000 PPO/$6000 NON PPO	
What is not included in the out-of-pocket limit?	Non-covered expenses	Even though you pay these expenses, they don't count toward your out-of-pocket limit
Will you pay less if you use a network provider?	Yes. Go to: https://public.hcsc.net/providerfinder/search or call 800-810-2583	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	

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	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	None
	Specialist visit	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	None
	Preventive care/screening/ immunization	No charge	25% co-insurance and balance billed the difference from the charge to the payment	None
If you have a test	Diagnostic test (x-ray, blood work)	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	None
	Imaging (CT/PET scans, MRIs)	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	None
If you need drugs to treat your illness or condition	Generic drugs	No charge		
	Preferred brand drugs	25% co-payment		
	Non-preferred brand drugs	45% co-payment		
	Specialty drugs	20% co-payment with a maximum of $100 per script		

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
	Physician/surgeon fees	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
If you need immediate medical attention	Emergency room care	15% co-insurance after the deductible has been met	15% co-insurance and balance billed the difference from the charge to the payment	
	Emergency medical transportation	15% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
	Urgent care	15% co-insurance after the deductible has been met	15% co-insurance and balance billed the difference from the charge to the payment	
If you have a hospital stay	Facility fee (e.g., hospital room)	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	Pre-cert is required. Please have provider call 800-635-1928
	Physician/surgeon fees	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	

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 mental health, behavioral health, or substance abuse services	Outpatient services	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	
	Inpatient services	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	Pre-cert if required. Please have provider call 800-851-7498
If you are pregnant	Office visits	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	
	Childbirth/delivery professional services	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
	Childbirth/delivery facility services	5% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
If you need help recovering or have other special health needs	Home health care	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	
	Rehabilitation services	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	
	Habilitation services	15% co-insurance after the deductible has been	20% co-insurance and balance billed the difference	

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)	
		met	from the charge to the payment	
	Skilled nursing care	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	
	Durable medical equipment	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	$15,000 Yearly max
	Hospice services	15% co-insurance after the deductible has been met	20% co-insurance and balance billed the difference from the charge to the payment	
If your child needs dental or eye care	Children's eye exam	No charge with VSP		
	Children's glasses	No charge with VSP		
	Children's dental check-up	80%	70%	

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.)

- Work related illness or injuries
- Cosmetic surgery
- Non-Emergency Transports

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

- Hearing aids, $2000 per ear every 5 years
- Orthotics-$500 every 3 years adults, every year children
- C-Pap machines covered every 5 years

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

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	$300.
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	5%
Other *[cost sharing]*	5%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)	*$1000*
Childbirth/Delivery Professional Services	$1000
Childbirth/Delivery Facility Services	$2000
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit *(anesthesia)*	*$1000*

Total Example Cost	**$5000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300.00
Copayments	$
Coinsurance	$235
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$535**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education)*	*$500*
Diagnostic tests *(blood work)*	*$250*
Prescription drugs	$200
Durable medical equipment *(glucose meter)*	

Total Example Cost	**$950**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$67.50
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$367.50**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*	*$1250*
Diagnostic test *(x-ray)*	*$ 300*
Durable medical equipment *(crutches)*	*$75*
Rehabilitation services *(physical therapy)*	*$1500*

Total Example Cost	**$3125**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$
Coinsurance	$423.75
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$723.75**

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