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 (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 at www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300per individual/$900 per family**	Generally you must pay all of the costs from the providers up to the deductible amount before this plan begins to pay. If you have other family members on this 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.	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 https:\\www.healthcare.gov/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?	**$2000 PPO/$6000 NON PPO**	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?	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.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	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	15% co-insurance after the deductible has been met	25% co-insurance and balance billed the difference from the charge to the payment	*From December 1, 2020 – December 31, 2021, the Fund will provide 100% coverage (no member cost share)* for in-network PPO physician "virtual" (phone or video) telehealth visits with your physician.
	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	*From December 1, 2020 – December 31, 2021, the Fund will provide 100% coverage (no member cost share)* for in-network PPO physician "virtual" (phone or video) telehealth visits with your physician.
	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 More information about prescription drug coverage is available at www.710hwp.org	Generic drugs	No charge. Effective 7/1/2021, up to 90 day supply at Sav-Rx Walk In Mail Order Retail Pharmacy		OptumRX Mail Order (800) 506-4671 3 month supply through June 30, 2021. **Effective July 1, 2021, Sav-Rx Mail Order (800) 228-3108.**
	Preferred brand drugs	25% of the Fund's cost		OptumRX Mail Order-$200 max out of pocket per script-3 month supply through June 30, 2021. **Effective July 1, 2021, Sav-Rx Mail Order (800) 228-3108.**
	Non-preferred brand drugs	45% of the Fund's cost		OptumRX mail order-$200 max out of

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)	
				pocket per script-3 month supply through June 30, 2021. **Effective July 1, 2021, Sav-Rx Mail Order (800) 228-3108.**
	Specialty drugs	25% of Fund's cost for the drug to a maximum of $100 per script		(800) 711-4555 through June 30, 2021. **Effective July 1, 2021, Sav-Rx (800) 228-3108.**
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	15% 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 after the deductible has been met	
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 is required. Please have provider call 800-851-7498. Treatment provided outside the Chicagoland area, unless patient lives outside Chicagoland area or is a bona fide emergency, is not covered unless the patient provides documentation that comparable treatment cannot be provided in this area.
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 met	25% co-insurance and balance billed the difference from the	

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)	
			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 max per calendar year
	Hospice services	15% co-insurance after the deductible has been met	25% 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	Paid in full	$40.00	VSP (800) 877-7195 or vsp.com
	Children's glasses	Lenses paid in full $150 allowance for frames	Single lens $60 Bifocal lens $70 Trifocal lens $80 Frames $80	
	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
- Non-Emergency Transports
-

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

- C-Pap machine every 5 years
- Hearing Aids-$2000/per ear/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: HFS 800-843-6154. 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: [insert applicable contact information from instructions].

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

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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.

■ **The plan's overall deductible**	**$300**
■ **Specialist *[cost sharing]***	**5%**
■ **Hospital (facility) *[cost sharing]***	**5%**
■ **Other *[cost sharing]***	**5%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	
Coinsurance	$620
What isn't covered	
Limits or exclusions	
The total Peg would pay is	**$620**

■ **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)*
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	$300
Copayments	
Coinsurance	$783.75
What isn't covered: non prescription medications	
Limits or exclusions	$75
The total Joe would pay is	**$1158.75**

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

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	$300
Copayments	
Coinsurance	$375
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$675**

675

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