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, 710hwp.org.
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.710hwp.org.com or call 1-773-254-2500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300 per 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 their own 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, 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:\\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?	**For Network providers: $2,000 Individual/$6,000 Family; For Out-of-Network providers: $9,450 Individual/$18,900 Family**	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?	Non-covered expenses	Even though you pay these expenses, they don't count toward your Out-of-Pocket limit unless they are claims paid in accordance with the "No Surprises Act."
Will you pay less if you use a network provider?	Yes. Go to https://www.bcbs.com/find-a-doctor	This plan uses a provider network. You will pay less if you use a provider in the plan's networks. 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 (
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% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Specialist visit	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Preventive care/screening/ immunization	no charge	25% coinsurance; deductible applies	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Imaging (CT/PET scans, MRIs)	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Savrx.com	Generic drugs	No charge	No charge	
	Preferred brand drugs	25% coinsurance	25% coinsurance	
	Non-preferred brand drugs	45% coinsurance	45% coinsurance	
	Specialty drugs	25% co-insurance max of $200 per script	not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Physician/surgeon fees	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
	Emergency medical transportation	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
	Urgent care	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance; deductible applies	20% coinsurance; deductible applies*	
	Physician/surgeon fees	5% coinsurance; deductible applies	20% coinsurance; deductible applies*	

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible only for the Network Copayment and Coinsurance.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Inpatient services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you are pregnant	Office visits	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Childbirth/delivery professional services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Childbirth/delivery facility services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home health care	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Rehabilitation services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Habilitation services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Skilled nursing care	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Durable medical equipment	15% coinsurance; deductible applies	25% coinsurance; deductible applies	$15,000 max payment per calendar year, excludes vehicle and home modifications, exercise, and bathroom equipment
	Hospice services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
If your child needs dental or eye care	Children's eye exam	paid in full	$60	VSP (800) 877-7195 vsp.com
	Children's glasses	up to $180	Up to $120	
	Children's dental check-up	20% coinsurance	30% coinsurance	

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

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

- Hearing Aids

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible only for the Network Copayment and Coinsurance.

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 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 al 773-254-2500.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 773-254-2500.

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码[773-254-2500.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 773-254-2500.

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

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible only for the Network Copayment and Coinsurance.

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]*	**15%**
Hospital (facility) *[cost sharing]*	**5%**
Other *[cost sharing]*	**15%**

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	$0
Coinsurance	5%
What isn't covered	
Limits or exclusions	none
The total Peg would pay is	**$620**

The plan's overall deductible	**$300**
Specialist *[cost sharing]*	**15%**
Hospital (facility) *[cost sharing]*	**5%**
Other *[cost sharing]*	**%**

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	$0
Coinsurance	15%
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$795**

The plan's overall deductible	**$300**
Specialist *[cost sharing]*	**15%**
Hospital (facility) *[cost sharing]*	**15%**
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	0
Coinsurance	15%
15%What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$375**

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