



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 773-385-9300. 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 <https://www.healthcare.gov/sbc-glossary> or call 773-385-9300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$100	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of <a href="#">covered preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500 In-Network Medical Benefit \$3,600 In-Network Prescription Drug Benefit	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Any amounts not paid by the Plan for out-of-network charges, non-covered charges, or penalties	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit their website <a href="http://www.advocatehealth.com">www.advocatehealth.com</a> or call 1-800-3ADVOCATE for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	\$10 <a href="#">copayment</a>	Not Covered	
	<a href="#">Specialist</a> visit	\$10 <a href="#">copayment</a>	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at OptumRx 1-888-354-0090	Generic drugs – Medication Cost at point of sale \$0-\$15 Greater than \$15	\$1 <a href="#">copayment</a> 40% <a href="#">coinsurance</a>	Not Covered	You must use your Optum prescription care to receive these discounts.
	Preferred brand drugs – Medication Cost at point of sale \$0 - \$30 Greater than \$30	\$8 <a href="#">copayment</a> 40% <a href="#">coinsurance</a>	Not Covered	You must use your Optum prescription care to receive these discounts.
	Non-preferred brand drugs – All Cost	40% <a href="#">coinsurance</a>	Not Covered	You must use your Optum prescription care to receive these discounts.
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a>	\$100 <a href="#">copayment</a>	\$100 <a href="#">copayment</a> is waived if admitted to the hospital.
	<a href="#">Emergency medical</a>	10% <a href="#">coinsurance</a> ;	10% <a href="#">coinsurance</a> ;	

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.seiuhcbenfund.org/>.]

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)	
	<a href="#">transportation</a>	<a href="#">deductible</a> applies	<a href="#">deductible</a> applies	
	<a href="#">Urgent care</a>	\$10 <a href="#">copayment</a>	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a>
	Physician/surgeon fees	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
	Inpatient services	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
If you are pregnant	Office visits	\$10 copayment	Not Covered	
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a>
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.seiuhcbenfund.org/>.]

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)	
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Subject to 90-day calendar year maximum. Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> .
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	Not Covered	Contact Hines & Associates, Inc. at 888-827-7926 or <a href="http://www.precertcare.com">www.precertcare.com</a> for <a href="#">preauthorization</a> . \$100 penalty for no <a href="#">preauthorization</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>Bariatric surgery (must meet all criteria: your Primary Care Physician has recommended the treatment, your Primary Care Physician states you are at least 100 pounds over your medically desirable weight, you have a body mass index of 45 or more, the obesity is a threat to your life due to life threatening co-morbidities, such as diabetes, heart disease, hypertension, etc., you have a documented history of unsuccessful attempts to reduce weight by more conservative measures, you have successfully completed a psychiatric evaluation and have no psychiatric conditions which may reduce the chances the surgery will have long-term success, you actively participate in a Disease Management program with Hines &amp; Associates for six months prior to surgery which includes nutritional counseling and a weight reduction program, and you have not had any form of bariatric surgery in the past. Revision bariatric surgeries are not covered under the Plan.</li> <li>Chiropractic care (Chiropractic Care is covered at 50% with a calendar maximum of 20 visits).</li> </ul>

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.seiuhcbfund.org/>.]

**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](http://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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 773-385-9300.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 773-385-9300.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 773-385-9300.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 773-385-9300.]

*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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$2
<a href="#">Coinsurance</a>	\$1200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1400</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$1700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1900</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other [\[cost sharing\]](#) 10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$110
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$400</b>

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