



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> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No	You will have to meet the deductible before the <a href="#">plan</a> pays for any services.
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 \$5,100 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.swedishamerican.org">www.swedishamerican.org</a> or call 1-779-696-4400 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	\$0	Not Covered	
	<a href="#">Specialist</a> visit	\$0	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>	Not Covered	
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	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>	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>	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>	\$200 <a href="#">copayment</a>	\$200 <a href="#">copayment</a>	\$200 <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="#">Urgent care</a>	\$25 <a href="#">copayment</a>	Not Covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	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>	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 you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a>	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>	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 you are pregnant</b>	Office visits	\$0	Not Covered	
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	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>	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 you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	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="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	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="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	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>	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>	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>	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)</li> </ul>

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

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

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 & 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.

- Chiropractic care (Chiropractic Care is covered at 50% with a calendar maximum of 20 visits).

**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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

## 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](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- 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>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2
<a href="#">Coinsurance</a>	\$1300
<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](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- 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>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1800</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- 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>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<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.