




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 deductible ? | \$5,000 In-network \$5,000 Out-of-Network | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and primary care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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/coverage/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 ? | \$6,000 In-Network Medical Benefit \$850 In-Network Prescription Drug Benefit | 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 ? | 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 out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. The network is HealthLink 1-800-624-2356 | 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 | \$20 copayment | 50% coinsurance ; deductible applies | |
| | Specialist visit | \$20 copayment | 50% coinsurance ; deductible applies | |
| | Preventive care/screening/immunization | No charge | Not Covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Optum 1-888-354-0090 | Generic drugs – Medication Cost at point of sale \$0-\$15 Greater than \$15 | 40% coinsurance | 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 | 40% coinsurance | Not Covered | You must use your Optum prescription care to receive these discounts. |
| | Non-preferred brand drugs – All Cost | 40% coinsurance | Not Covered | You must use your Optum prescription care to receive these discounts. |
| | Specialty drugs | Not Covered | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . |
| | Physician/surgeon fees | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| If you need immediate medical attention | Emergency room care | \$500 copayment | \$500 copayment | |
| | Emergency medical transportation | 30% coinsurance ; deductible applies | 30% coinsurance ; deductible applies | |

[* For more information about limitations and exceptions, see the [plan](#) or policy document or by calling 773-385-9300.]

| 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) | |
| | Urgent care | \$50 copayment | 50% coinsurance ; deductible applies | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| | Physician/surgeon fees | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 30% coinsurance | 50% coinsurance ; deductible applies | |
| | Inpatient services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| If you are pregnant | Office visits | \$20 copayment | 50% coinsurance ; deductible applies | |
| | Childbirth/delivery professional services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . |
| | Childbirth/delivery facility services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| | Rehabilitation services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |

| 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) | |
| | Habilitation services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| | Skilled nursing care | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Subject to 90-day calendar year maximum (in and out-of-network benefits combined). Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| | Durable medical equipment | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . |
| | Hospice services | 30% coinsurance ; deductible applies | 50% coinsurance ; deductible applies | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization . \$500 penalty for no preauthorization . |
| If your child needs dental or eye care | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental care (Adult) • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Chiropractic care | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs |

[* For more information about limitations and exceptions, see the [plan](#) or policy document or by calling 773-385-9300.]

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

- 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 & 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.

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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](#) \$5000
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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 | \$5000 |
| Copayments | \$0 |
| Coinsurance | \$2310 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$7310 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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 | \$1215 |
| Copayments | \$20 |
| Coinsurance | \$1400 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2650 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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 | \$945 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1440 |

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