



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 ?	\$100	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 ?	\$3,500 In-Network Medical Benefit \$2,100 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 Union Medical Center 1-312-829-1134	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 ?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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	
	Specialist visit	10% coinsurance ; deductible applies	Not Covered	
	Preventive care/screening/immunization	No charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance ; deductible applies	Not Covered	
	Imaging (CT/PET scans, MRIs)	10% coinsurance ; deductible applies	Not Covered	
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	\$1 copayment 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	\$8 copayment 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)	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Physician/surgeon fees	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
If you need immediate medical attention	Emergency room care	\$200 copayment	\$200 copayment	\$200 copayment is waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance ; deductible applies	10% coinsurance ; deductible applies	
	Urgent care	\$25 copayment	Not Covered	

[* 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Physician/surgeon fees	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Inpatient services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
If you are pregnant	Office visits	0%	Not Covered	
	Childbirth/delivery professional services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Childbirth/delivery facility services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
If you need help recovering or have other special health needs	Home health care	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Rehabilitation services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Habilitation services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Skilled nursing care	10% coinsurance ; deductible applies	Not Covered	Subject to 90-day calendar year maximum. UMC referral is needed.
	Durable medical equipment	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
	Hospice services	10% coinsurance ; deductible applies	Not Covered	UMC referral is needed.
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	

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

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](#).)

- | | | |
|-----------------------|--|----------------------------|
| • Acupuncture | • Infertility treatment | • Private-duty nursing |
| • Cosmetic Surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Hearing aids | | • Weight loss programs |

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.
- 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. 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, kwiiijigo 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$1200
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1360

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$1510
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1530

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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$380

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