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 www.dol.gov or call 773-385-9300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
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?	$3,000 In-Network Medical Benefit $3,600 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 Health Service 1-312-423-4200	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	$10 copayment if you use UHS on Polk St.
	Specialist visit	$0	Not Covered	UHS Referral is needed.
	Preventive care/screening/ immunization	No charge	Not Covered	UHS Referral is needed.
If you have a test	Diagnostic test (x-ray, blood work)	0%	Not Covered	UHS Referral is needed.
	Imaging (CT/PET scans, MRIs)	0%	Not Covered	UHS Referral is needed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Union Health Service (UHS) 1-312-423-4200	Generic drugs	$1 copayment	Not Covered	Call UHS 312-423-4200. Copayments subject to change depending on the brand, dosage, or quantity.
	Preferred brand drugs	$8 copayment	Not Covered	Call UHS 312-423-4200. Copayments subject to change depending on the brand, dosage, or quantity.
	Non-preferred brand drugs	100% coinsurance	Not Covered	Call UHS 312-423-4200.
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0%	Not Covered	UHS Referral is needed.
	Physician/surgeon fees	0%	Not Covered	
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment	$200 copayment is waived if admitted to the hospital. You must call UHS no later than 48 hours after treatment. UHS Referral is needed. If you receive treatment in a hospital emergency room for a condition that DOES NOT meet the Plan's definition of an emergency, the benefits you would have otherwise received for that treatment will be reduced by 50%.
	Emergency medical transportation	0%	$0	UHS Referral is needed.

[* For more information about limitations and exceptions, see the plan or policy document 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	0%	Not Covered	UHS Referral is needed.
If you have a hospital stay	Facility fee (e.g., hospital room)	0%	Not Covered	UHS Referral is needed.
	Physician/surgeon fees	0%	Not Covered	UHS Referral is needed.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment per visit	Not Covered	UHS Referral is needed.
	Inpatient services	0%	Not Covered	UHS Referral is needed.
If you are pregnant	Office visits	0%	Not Covered	UHS Referral is needed.
	Childbirth/delivery professional services	0%	Not Covered	UHS Referral is needed.
	Childbirth/delivery facility services	0%	Not Covered	UHS Referral is needed.
If you need help recovering or have other special health needs	Home health care	0%	Not Covered	UHS Referral is needed.
	Rehabilitation services	0%	Not Covered	UHS Referral is needed.
	Habilitation services	0%	Not Covered	UHS Referral is needed.
	Skilled nursing care	0%	Not Covered	Subject to 90-day calendar year maximum. UHS Referral is needed.
	Durable medical equipment	0%	Not Covered	UHS Referral is needed.
	Hospice services	0%	Not Covered	UHS 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	

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
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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
- Chiropractic care (Chiropractic Care is covered at 50% with a calendar maximum of 20 visits).

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

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwiijigo holne' 773-385-9300.]

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 by calling 773-385-9300.]

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]*** **0%**
- **Other *[cost sharing]*** **0%**

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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]*** **0%**
- **Other *[cost sharing]*** **0%**

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$9
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$60**

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]*** **0%**
- **Other *[cost sharing]*** **0%**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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