**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?** | $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?** | No | You will have to meet the deductible before the plan pays for any services. |
| **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<br>$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. Visit their website www.swedishamerican.org or call 1-779-696-4400 for a list of network providers. | 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 | $0 | Not Covered | |
| | Specialist visit | $0 | Not Covered | |
| | Preventive care/screening/ immunization | No charge | Not Covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | Not Covered | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at OptumRx 1-888-354-0090 | Generic drugs – Medication Cost at point of sale $0-$15<br>Greater than $15 | $1 copayment<br>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<br>Greater than $30 | $8 copayment<br>40% copayment | 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 | Not Covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization.<br>$100 penalty for no preauthorization. |
| | Physician/surgeon fees | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization.<br>$100 penalty for no preauthorization. |
| **If you need immediate medical attention** | Emergency room care | $200 copayment | $200 copayment | $200 copayment is waived if admitted to the hospital. |
| | Emergency medical | 10% coinsurance | 10% coinsurance | |

| 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) | |
| | transportation | | | |
| | Urgent care | $25 copayment | Not Covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Physician/surgeon fees | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Inpatient services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| **If you are pregnant** | Office visits | $0 | Not Covered | |
| | Childbirth/delivery professional services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Childbirth/delivery facility services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 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) | |
| | Rehabilitation services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Habilitation services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Skilled nursing care | 10% coinsurance | Not Covered | Subject to 90-day calendar year maximum. Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 penalty for no preauthorization. |
| | Durable medical equipment | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. |
| | Hospice services | 10% coinsurance | Not Covered | Contact Hines & Associates, Inc. at 888-827-7926 or www.precertcare.com for preauthorization. $100 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.)**

- 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

| 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. 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 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.

**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 773-385-93003]

[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.*

## 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $2 |
| Coinsurance | $1300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1400** |

### 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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $30 |
| Coinsurance | $1700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1800** |

### 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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

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