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 1-800-345-9474. 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 www.hshs.org/myhr or by calling 1-800-345-9474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	HSHS Facility/PCP: Individual (Ind) $0/Family (Fam) $0. Other Network Providers: Ind $1,800/Fam $3,600 Out–of–Network: No Coverage	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. *Out-of-network services – must receive referral from Health Choices.*
Are there services covered before you meet your deductible?	Yes	Wellness and preventive care is covered at 100%, not subject to the deductible.
Are there other deductibles for specific services?	Yes. $400 per person for prescription drug expenses.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual $3,800/Family $7,600. Out–of–Network: No Coverage Separate Prescription Drug Out-of-Pocket Limit $1,600 per person/$3,200 Family Limit	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. *Out-of-network services – must receive referral from Health Choices.*
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	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	You must obtain referral from Health Choices for out-of-network providers
Do you need a referral to see a specialist?	No	You can see the network specialist you choose without permission from this plan.

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	For Colleagues Living in Live360 Network Service Area	For Colleagues Living Outside Live360 Network Service Area	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (Internist, General Physician, Family Practitioner or Pediatrician)	HSHS no charge, deductible waived All Others 20% coinsurance	HSHS no charge, deductible waived All Others 20% coinsurance	Not covered *Must receive referral from Health Choices*	HSHS includes HSHS Medical Group, Prairie Cardiovascular Consultants, and Prevea
	Specialist visit	25% coinsurance	25% coinsurance	Not covered *Must receive referral from Health Choices*	Deductible applies for most non-office visit charges
	Preventive care/ screening/ immunization	No charge	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	PCP/specialist/HSHS facility 25% coinsurance, deductible waived; All Other Facilities 35% coinsurance after deductible	25% coinsurance deductible waived;	Not covered *Must receive referral from Health Choices*	————none————
	Imaging (CT/PET scans, MRIs)	PCP/specialist/HSHS facility 25% coinsurance, deductible waived; All Other Facilities 35% coinsurance after deductible	25% coinsurance deductible waived;	Not covered *Must receive referral from Health Choices*	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	HSHS 10% coinsurance after deductible All Others 20% coinsurance after deductible	Not covered	A separate prescription drug out-of-pocket limit of $1,600 per person/ $3,200 Family Limit applies. Retail - 30 day supply Mail - 90 day supply If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and generic coinsurance. Maintenance medications at HSHS, mail order or Walgreens required for coverage after the second fill at a retail pharmacy. After the initial fill, specialty medications must be filled through OptumRx or HSHS to be covered. Prior authorization may be required.
	Preferred brand drugs	HSHS 20% coinsurance after deductible All Others 30% coinsurance after deductible	Not covered	
	Non-preferred brand drugs	HSHS 20% coinsurance after $15 copay per 30-day supply and deductible All Others 30% coinsurance after $15 copay and deductible Mail Order - $45 copay then 30% coinsurance	Not covered	
	Specialty drugs	HSHS 20% coinsurance after deductible All Others 30% coinsurance after deductible	Not covered	

Common Medical Event	Services You May Need	For Colleagues Living in Live360 Network Service Area	For Colleagues Living Outside Live360 Network Service Area	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	HSHS 25% coinsurance, deductible waived All Others 35% coinsurance after deductible	25% coinsurance, deductible waived	Not covered	Pre-authorization may be required.
	Physician/surgeon fees	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible	Not covered	Must receive referral from Health Choices for out-of-network providers
If you need immediate medical attention	Emergency room care	25% coinsurance after $100 copay, deductible waived; Physician 25% coinsurance after deductible	25% coinsurance after $100 copay, deductible waived; Physician 25% coinsurance after deductible	25% coinsurance after $100 copay, deductible waived; Physician 25% coinsurance after deductible	
	Emergency medical transportation	25% coinsurance, deductible waived	25% coinsurance, deductible waived	25% coinsurance, deductible waived	For non-emergency medical transport, you must receive referral from Health Choices
	Urgent care	25% coinsurance deductible waived;	25% coinsurance deductible waived;	Not covered	Must receive referral from Health Choices for OON providers
If you have a hospital stay	Facility fee (e.g., hospital room)	HSHS 25% coinsurance All Other 35% after deductible	25% coinsurance	Not covered	Pre-authorization required.
	Physician/surgeon fees	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible	Not covered	Must receive referral from Health Choices for OON providers

Common Medical Event	Services You May Need	For Colleagues Living in Live360 Network Service Area	For Colleagues Living Outside Live360 Network Service Area	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP 5% coinsurance Specialist 25% coinsurance Facility 25% coinsurance	PCP 5% coinsurance, Specialist 25% coinsurance Facility 25% coinsurance	Not covered	Deductible waived
	Inpatient services	PCP - 5% coinsurance Specialist 25% coinsurance Facility 25% coinsurance	PCP 5% coinsurance Specialist 25% coinsurance Facility 25% coinsurance	Not covered	Deductible waived. Pre-authorization required.
If you are pregnant	Office visits	HSHS no charge; All Other PCPs 20% coinsurance Specialists 25% coinsurance;	HSHS no charge; All Other PCPs 20% coinsurance Specialists 25% coinsurance;	Not covered	Deductible waived
	Childbirth/delivery professional services	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible;	PCP 5% coinsurance, deductible waived Specialist 25% coinsurance after deductible;	Not covered	Includes outpatient postnatal care.
	Childbirth/delivery facility services	HSHS 25% coinsurance, deductible waived All Other 35% after deductible	25% coinsurance, deductible waived	Not covered	Pre-authorization may be required.

Common Medical Event	Services You May Need	For Colleagues Living in Live360 Network Service Area	For Colleagues Living Outside Live360 Network Service Area	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	Not covered	Coverage limited to 120 visits per calendar year. Pre-authorization required. Deductible waived.
	Rehabilitation services	25% coinsurance	25% coinsurance	Not covered	Deductible waived
	Habilitation services	25% coinsurance	25% coinsurance	Not covered	Deductible waived
	Skilled nursing care	25% coinsurance	25% coinsurance	Not covered	Coverage is limited to 180 days per calendar year. Deductible waived. Pre-authorization required.
	Durable medical equipment	25% coinsurance	25% coinsurance	Not covered	Deductible waived.
	Hospice services	25% coinsurance	25% coinsurance	Not covered	Pre-authorization required. Deductible waived.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	————none————
	Children's glasses	Not covered	Not covered	Not covered	————none————
	Children's dental check-up	Not covered	Not covered	Not covered	————none————

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.)

- Cosmetic Surgery
- Dental Care (Adult & Child)
- Glasses (Adult & Child)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs – except for required preventive services

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

- Acupuncture
- Bariatric surgery – Coverage limited to HSHS contracted facilities only
- Spinal manipulations – Coverage is limited to 10 visits per calendar year
- Hearing aids – Up to $1,400 per hearing aid every 3 years
- Infertility testing– Coverage is limited to the diagnosis and treatment of underlying medical condition
- Private-duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plan, 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.

* For more information about limitations and exceptions, see the plan or policy document at www.hshs.org/myhr

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-982-3862.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-982-3862.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

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	$1,800
Specialist Coinsurance	25%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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	$1,810
Copayments	$0
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,570

Example assumes all services received from in-network providers.

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,800
Specialist Coinsurance	25%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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	$520
Copayments	$0
Coinsurance	$840
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,380

Example assumes all services received from in-network providers.

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,800
Specialist Coinsurance	25%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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	$520
Copayments	$100
Coinsurance	$540
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,160

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