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, contact your Human Resources Department. 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.consociate.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000**/individual for network providers or **$10,000**/individual for out-of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and other services listed with 0% coinsurance 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 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?	For network providers: **$7,900**/ individual or **$15,800**/family; for out-of-network providers: **$15,800**/individual or **$31,600**/family	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?	Premiums, copays (except to the extent required under the Affordable Care Act), balance-billing charges, and health care this plan doesn't cover and penalties for failure to follow plan requirements.	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. Employees can choose between OSF Direct Access Network (888-209-3761 or www.osfdirectaccessnetwork.com) or Unity Point Health Plus Network (866-510-2922 or www.healthpluspeoria.com)	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.	This plan will pay some or all of the costs to see a specialist for covered.

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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% coinsurance	50% coinsurance	None
	OSF On-Call visit (Member must submit receipt to Consociate in order for $35 charge to be applied to deductible and out-of-pocket limit)	$35 charge will apply towards member's deductible. If deductible has been met, charge will be subject to 20% coinsurance.	NA	
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ldirx.com	Generic drugs	$7/prescription for 30 day supply retail; $14/prescription for 60 day supply retail and mail; $21/prescription for 90 day retail	Not covered	Covers up to a 30-day supply with a 90-day supply maximum (retail prescription); a 60-90-day supply (mail order prescription). If a patient insists on a brand name medication when there is a generic available and the physician's prescription allows for a generic to be dispensed, a penalty will be added to the applicable co-payment. This penalty is the difference in price between the brand name medication and its available generic.
	Preferred brand name drugs	20% coinsurance with $50 maximum for 30 day supply retail; 20% coinsurance with $100 maximum for 60 day supply retail and 60-90 day supply mail; 20% coinsurance with $150 maximum for 90 day supply retail		
	Non-preferred brand drugs	20% coinsurance with $75 maximum for 30 day supply retail; 20% coinsurance with $150 maximum for 60 day supply retail and 60-90 day		

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)	
		supply for mail; 20% coinsurance with $225 maximum for 90 day supply retail		
	Specialty drugs	$75/prescription for 30 day supply retail		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$150/visit then 20% coinsurance (true emergency) or $300/visit then 20% coinsurance (non-emergency)		None
	Emergency medical transportation	20% coinsurance	50% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	Emergency room benefits apply for urgent care room in the emergency room.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced. Semi-private room rate applies.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization is required for inpatient and cardiac rehabilitation. If you don't get preauthorization, benefits could be reduced.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization is required for DME >$500. If you don't get preauthorization, benefits could be reduced.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization for inpatient is required. If you don't get preauthorization, benefits could be reduced. Bereavement counseling is limited to 6 sessions in a 12 month period.
If your child needs dental or eye care	Children's eye exam	Plan pays $200 for all vision services combined every 24 months		Exam is limited to one exam every 24 months per covered person.
	Children's glasses	Plan pays $200 for all vision services combined every 24 months		Frames are limited to one set of frames every 24 months. Lenses are limited to two lenses every 24 months.
	Children's dental check-up	No charge		Limited to $1,000 per calendar year, to include preventive, basic and major services combined.

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture (30 visits per calendar year, combined with chiropractic care)
- Chiropractic care (30 visit per calendar year, combined with acupuncture)
- Dental care ($1,000 per calendar year, to include preventive, basic and major services combined)
- Hearing aids (subject to wellness benefits)
- Private-duty nursing
- Routine foot care (only for patients with Type I or II Diabetes)

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: Consociate – 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-232 x 61565 or www.cciio.cms.gov. 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: Consociate – 1-800-798-2422. You can also contact the 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 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. Contact Consociate, and you will be referred to a translator, if available:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-798-2422.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422.]

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	$5000
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$50
Coinsurance	$1,560
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,670**

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 copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$600
Coinsurance	$480
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,140**

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

The plan's overall deductible	$5000
Specialist and ER copayment	$150
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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