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?	**$1,000** person / **$3,000** family for HealthLink Open Access PPO, other PPO, and Non-PPO providers. Doesn't apply to certain preventive care	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 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?	There are no other specific deductible.	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?	Yes. **$2,500** person / **$6,250** family for PPO providers and **$5,000** person / **$15,000** family for Non-PPO providers.	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, balance-billed charges, dental or vision charges, prescription drug co-pays, copays, utilization review penalties, ineligible charges and health care this plan doesn't 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. Healthlink Open Access III is your In-Network Provider. See www.healthlink.com for a list of participating 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 do not need a referral to see a specialist.	You do not need 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
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	Network PPO Provider	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	$35 copayment/visit (up to $200) then 10% coinsurance	$35 copayment/visit (up to $200) then 20% coinsurance	50% coinsurance	Chiropractic Care is limited to $1,000 per calendar year.
	Specialist visit	$50 copayment/visit (up to $200) then 10% coinsurance	$50 copayment/visit (up to $200) then 20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	Covered at 100%	Covered at 100%	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)	10% coinsurance	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	50% coinsurance	Services must be pre-certified in order to avoid a $250 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.serve-you-rx.com	Generic drugs (Tier 1)	$10/prescription (retail), and $20/prescription (mail order)		Not Covered (unless emergency)	If physician approves the use of a chemically equivalent generic drug and you request a brand name drug, you will pay the copayment plus the cost difference between the brand and generic. Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$35/prescription (retail), and $70/prescription (mail order)		Not Covered (unless emergency)	
	Non-preferred brand drugs (Tier 3)	$50/prescription (retail), and $100/prescription (mail order)		Not Covered (unless emergency)	
	Specialty drugs (Tier 4)	Covered at applicable Rx co-pay. If not available under Rx program, covered under Major Medical.		Not Covered (unless emergency)	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	15% coinsurance	50% coinsurance	Preauthorization is required
	Physician/surgeon fees	15% coinsurance	15% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment, then 10% coinsurance	$150 copayment, then 20% coinsurance	$150 copayment, then 20% coinsurance after deductible	For facility-to-facility air ambulance transports, preauthorization is required through Sentinel Air Medical Alliance: 1-877-542-8828.
	Emergency medical transportation	10% coinsurance	20% coinsurance	50% coinsurance	
	Urgent care	$35 copayment/visit (up to $200) then 10% coinsurance	$35 copayment/visit (up to $200) then 10% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for all inpatient stays. Limited to the semi-private room rate.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required
	Inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for all inpatient stays
If you are pregnant	Office visits	10% coinsurance	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
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	Network PPO Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	50% coinsurance	SBC (i.e. ultrasound). Preauthorization is required for all inpatient stays
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	50% coinsurance	Limited to 40 visits per calendar year.
	Rehabilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. Physical, Occupational, and Speech Therapy limited to 25 visits each.
	Habilitation services	10% coinsurance	20% coinsurance	50% coinsurance	
	Skilled nursing care	50% coinsurance	50% coinsurance	50% coinsurance	Within 14 days of hospital confinement. Preauthorization is required
	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchases and rental equipment (up to the purchase price). Preauthorization is required
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge		50% coinsurance	Limited to one exam between ages 3-5.
	Children's glasses	Not covered			
	Children's dental check-up	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Glasses (Child)
- 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.)
• Chiropractic Care ($1,000 per calendar year)

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/healthreform 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	$1,000
Specialist coinsurance	20%
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	$1,000
Copayments	$20
Coinsurance	$2,326
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$3,476**

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

The plan's overall deductible	$1,000
Specialist coinsurance	20%
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	$1,000
Copayments	$850
Coinsurance	$1,094
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$3,024**

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

The plan's overall deductible	$1,000
Specialist coinsurance	20%
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	$1,000
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

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