
 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](http://www.consociate.com) or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$3,000</b> person / <b>\$6,000</b> family for HealthLink Open Access PPO, other PPO, and Non-PPO providers.                      Doesn't apply to certain preventive care</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>There are no other specific <a href="#">deductible</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Yes. <b>\$3,000</b> person / <b>\$6,000</b> family for PPO providers and <b>\$6,000</b> person / <b>\$12,000</b> family for Non-PPO providers.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>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.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.healthlink.com">www.healthlink.com</a> for a list of participating providers and <i>If elected</i> see <a href="http://www.hfninc.com">www.hfninc.com</a> for a list of participating providers within Knox, Tazewell and Peoria Counties "in Illinois"</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No. You do not need a referral to see a specialist.</p>	<p>This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services you do not need a <a href="#">referral</a> before you see the <a href="#">specialist</a>.</p>

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Applies to medical deductible.		50% <a href="#">coinsurance</a>	Chiropractic Care is limited to \$1,000 per calendar year.
	<a href="#">Specialist</a> visit	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	Covered at 100%		50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Applies to medical deductible.		50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	Applies to medical deductible.		50% <a href="#">coinsurance</a>	Services must be pre-certified in order to avoid a \$250 penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.serve-you-rx.com">www.serve-you-rx.com</a>	Generic drugs (Tier 1)	Applies to medical deductible.		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)			Not Covered (unless emergency)	
	Non-preferred brand drugs (Tier 3)			Not Covered (unless emergency)	
	<a href="#">Specialty drugs</a> (Tier 4)			Not Covered (unless emergency)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Applies to medical deductible.		Applies to medical deductible	For facility-to-facility air ambulance transports, <a href="#">preauthorization</a> is required through Sentinel Air Medical Alliance: 1-877-542-8828.
	<a href="#">Emergency medical transportation</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	

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 a hospital stay	Facility fee (e.g., hospital room)	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for all inpatient stays. Limited to the semi-private room rate.
	Physician/surgeon fees	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	Inpatient services	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for all inpatient stays
If you are pregnant	Office visits	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for all inpatient stays
	Childbirth/delivery professional services	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	Limited to 40 visits per calendar year.
	<a href="#">Rehabilitation services</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Physical, Occupational, and Speech Therapy limited to 25 visits each.
	<a href="#">Habilitation services</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	Within 14 days of hospital confinement. <a href="#">Preauthorization</a> is required
	<a href="#">Skilled nursing care</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	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). <a href="#">Preauthorization</a> is required
	<a href="#">Durable medical equipment</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	Applies to medical deductible.		50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	No charge		50% <a href="#">coinsurance</a>	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](http://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](http://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](http://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](http://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, kwijigo 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](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$150
<b>The total Peg would pay is</b>	<b>\$3,150</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$80
<b>The total Joe would pay is</b>	<b>\$3,080</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>