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?	$0/Individual or $0/family	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, there is no deductible	
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?	NA	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?	NA	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. See www.unitypoint.org/Peoria or call 1-866-510-2922 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. Note that charges billed by OSF Hospital will be cut 50%, and the plan will pay 90% of the remaining balance after the deductible.
Do you need a referral to see a specialist?	No.	This plan will pay some of the costs to see a specialist for covered services.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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 copay/visit	$0 copay/visit	Excess over UCR for Out-of-Network
	Specialist visit	$0 copay/visit	$0 copay/visit	Excess over UCR for Out-of-Network
	Preventive care/screening/ immunization	$0 copay/visit	$0 copay/visit	Excess over UCR for Out-of-Network
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	Excess over UCR for Out-of-Network
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$0 copay/prescription/ *$12 copay/prescription retail; $15 copay/prescription Mail order.	Not covered	Other plan co-pays may be reimbursed. *If Participant does not have a Prescription Drug Plan through the Spouse's Plan, the Participant will have coverage through the Illinois Central College Prescription Drug Benefits, but the co-payments will not be reimbursed.
	Brand drugs	$0 copay/prescription/ *$25 copay/prescription retail; $27copay/prescription Mail Order	Not covered	
	Brand drugs	$0 copay/prescription/ *$55 copay/prescription retail; $54 copay/prescription Mail Order	Not covered	
	Specialty drugs	$0 copay/prescription/ *$150 copay/prescription retail only	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No-Loss may apply
	Physician/surgeon fees	Not covered	Not covered	Expenses over UCR for Out-of-Network
If you need immediate	Emergency room care	Not covered	Not covered	No-Loss may apply

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)	
medical attention	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No-Loss may apply
	Physician/surgeon fees	Not covered	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No-Loss may apply
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Not covered	Not covered	No-Loss may apply
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No-Loss may apply
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	Excess over UCR
	Children's glasses	Excess over $125	Excess over $125	
	Children's dental check-up	20% coinsurance	20% coinsurance	Excess over UCR

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 (if prescribed for rehabilitation purposes)
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Routine Foot Care
- Chiropractic Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Dental Care	• Most coverage provided outside the United States	• Routine eye care

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? **This Plan or policy does not provide minimum essential coverage,** but the Employer does offer coverage that meets minimum essential coverage. If you don't have Minimum Essential Coverage for a month, you may 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? **This Plan or policy does not meet minimum value standards**, but the Employer does offer coverage that meets minumum value standards. 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	$ 0
Specialist copayment	$ 0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments for prescriptions	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,000
The total Peg would pay is	**$11,000**

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

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	$0
Copayments for prescriptions	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,100
The total Joe would pay is	**$7,100**

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

The plan's overall deductible	$ 0
Specialist copayment	$ 0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments for prescriptions	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

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