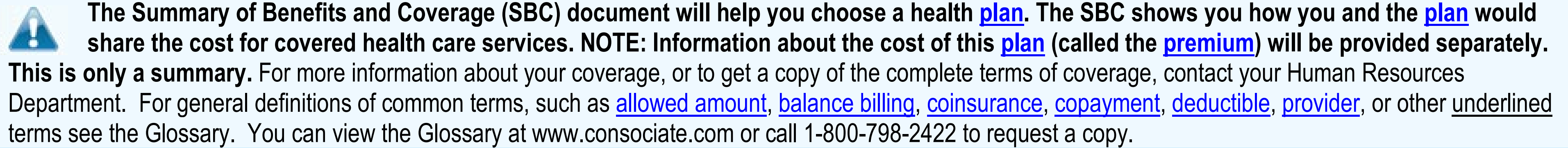

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. 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?	For In-Network Providers: **$300** per individual / **$900** per family. For Out-of-Network Providers: **$300** per individual / **$900** per 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. Certain Preventive care and primary care services are covered before you meet your deductible. Prescription drugs purchased with the drug card require a copayment but 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..
Are there other deductibles for specific services?	No, there are no other specific deductibles.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$1,000** Person **/ $3,000** Family; Out-of-Network: **$10,000** Person/**$10,000** 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, prescription drug benefits, Out-of-Network transplant expenses, balance-billed charges, penalties for failure to obtain preauthorization, 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. You may choose either **UnityPoint Health Plus+** or **OSF-Direct Access Network** to be your network. For a list of preferred providers, see www.consociatehealth.com or call 1-800-798-2422.	This plan uses provider networks. 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.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	20% coinsurance after deductible	40% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	
	Routine/Preventive Adult and Child Care - office visits, labs, x-rays, vision/hearing screening, immunizations, child flu/pneumonia immunizations, immunization	No Charge	Not Covered	None
	Routine/Preventative Pap smear, Mammogram, PSA Testing, breast feeding support and supplies, adult care flu/pneumonia immunizations	No Charge	40% coinsurance after deductible	
	Routine/Preventative Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related services)	20% coinsurance after deductible	40% coinsurance after deductible	

All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs) at a physicians office.	20% coinsurance. No deductible.	40% coinsurance. No deductible.	None
	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs) at an in-patient or out-patient facility.	20% coinsurance. No deductible.	40% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.castiarx.com	Generic drugs (Tier 1)	$5 Copay per 30-day supply (retail); $10 Copay per 90-day supply (mail order or retail)	$5 Copay per 30-day supply (retail); $10 Copay per 90-day supply (mail order or retail)	Deductible does not apply
	Preferred brand drugs (Tier 2)	$10 Copay per 30-day supply (retail); $20 Copay per 90-day supply (mail order or retail)	$10 Copay per 30-day supply (retail); $20 Copay per 90-day supply (mail order or retail)	
	Non-preferred brand drugs (Tier 3)	$40 Copay per 30-day supply (retail); $80 Copay per 90-day supply (mail order or retail)	$40 Copay per 30-day supply (retail); $80 Copay per 90-day supply (mail order or retail)	
	Specialty drugs (Tier 4)	$10 Copay per 30 day supply;	$10 Copay per 30 day supply;	Preauthorization is required for some Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. No deductible.	40% coinsurance. No deductible.	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance. No deductible.		For Physician/Profession fees at Emergency Room, you pay 20% coinsurance AFTER deductible
	Emergency medical transportation	20% coinsurance after deductible		None
	Urgent care	20% coinsurance. No deductible.	20% coinsurance. No deductible.	None

All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required or the first $200 of covered expense will not be covered.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance. No deductible.	None
	Inpatient services	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required or the first $200 of covered expense will not be covered.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Depending on the type of services, a coinsurance or deductible may apply
	Childbirth/delivery facility services	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or the first $200 of covered expense will not be covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance. No deductible. .	40% coinsurance. No deductible .	Home Health Care Services limited to 80 visits per calendar year. Outpatient private duty nursing covered up to $12,000 per person per calendar year.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Respiratory and pulmonary therapy, chemotherapy
	Habilitation services	20% coinsurance. No deductible.	40% coinsurance after deductible	Occupational, speech, physical, cognitive therapy, cardiac rehab

All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
				phase I and II
	Skilled nursing care	20% coinsurance. No deductible.	40% coinsurance. No deductible.	Short term non-custodial care limited to 81 days per calendar year
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	None
	Hospice services	20% coinsurance. No deductible.	40% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Routine Vision Screening Only
	Children's glasses	Not Covered	Not Covered	Excluded service
	Children's dental check-up	As covered under dental plan	As covered under dental plan	See Dental Plan

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
- Custom Molded Orthotics
- Dental Care – Covered under dental plan
- Jaw Joint/TMJ
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside of the U.S.
- 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
- Hearing Aids-Limited to cochlear/auditory brain stem implants
- Routine Vision/Hearing (Adult/Child) screening only
- Infertility – Diagnosis Only

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** **$300**
- **Specialist copayment** **N/A**
- **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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **20%**
- **Prescription copayment** **$10**

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **20%**
- **Other emergency room copayment** **N/A**

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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$720**

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