



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.consociate.com or by calling 1-800-798-2422.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,000 person / \$6,000 family for HealthLink Open Access PPO, other PPO, and Non-PPO providers. Doesn't apply to office visit copayment.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$3,500 person / \$6,500 family for PPO providers and \$9,000 person / \$21,000 family for Non-PPO providers.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental or vision charges, deductibles, copayments, utilization review penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.healthlink.com for a list of participating providers and <i>If elected</i> see www.hfninc.com for a list of participating providers within Knox, Tazewell and Peoria Counties "in Illinois"	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	PPO Provider	Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35/visit (up to \$200) then 10% coinsurance	\$35/visit (up to \$200) then 20% coinsurance	50% coinsurance	—————none—————
	Specialist visit	\$50/visit (up to \$200) then 10% coinsurance	\$50/visit (up to \$200) then 20% coinsurance	50% coinsurance	—————none—————
	Other practitioner office visit	10% coinsurance for chiropractor	20% coinsurance for chiropractor	50% coinsurance for chiropractor	Chiropractic care is limited to \$1,000 per calendar year.
	Preventive care/screening/immunization	No charge		50% coinsurance	—————none—————
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.

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Western Area Schools: Red Plan \$2,000

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Single, Employee+1, Employee+2, Employee+3 or more | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	PPO Provider	Non-PPO Provider	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medtrakservices.com .	Generic drugs	\$10/prescription (retail), and \$20/prescription (mail order)		Not covered	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 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Brand Preferred Formulary drugs	\$35/prescription (retail), and \$70/prescription (mail order)			
	Brand Non-Preferred drugs	\$50/prescription (retail), and \$100/prescription (mail order)			
	Specialty drugs	Covered at applicable Rx co-pay. If not available under Rx program, covered under Major Medical.		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance		50% coinsurance	_____none_____
	Physician/surgeon fees	10% coinsurance	15% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	\$150/visit then 10% coinsurance	\$150/visit then 20% coinsurance	\$150/visit then 50% coinsurance	_____none_____
	Emergency medical transportation	10% coinsurance	20% coinsurance	50% coinsurance	_____none_____
	Urgent care	\$35/visit (up to \$200) then 10% coinsurance	\$35/visit (up to \$200) then 20% coinsurance	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	50% coinsurance	Limited to the semi-private room rate. Services must be pre-certified.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	50% coinsurance	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use a			Limitations & Exceptions
		HealthLink Open Access Provider and (if elected) HFN CHC Elite Provider in Knox and Peoria County	PPO Provider	Non-PPO Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
If you are pregnant	Prenatal and postnatal care	No charge		50% coinsurance	—————none—————
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	—————none—————
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. Pre-Certification is required
	Rehabilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Limited to \$1,500 per sickness or injury. Pre-Certification is required
	Habilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Limited to \$1,500 per sickness or injury. Pre-Certification is required
	Skilled nursing care	50% coinsurance	50% coinsurance	50% coinsurance	Within 14 days of hospital confinement. Pre-Certification is required
	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
	Hospice service	10% coinsurance	20% coinsurance	50% coinsurance	Pre-Certification is required in order to avoid a penalty
If your child needs dental or eye care	Eye exam	No charge		50% coinsurance	Limited to one exam between ages 3-5.
	Glasses	Not covered			Not covered.
	Dental check-up	Not covered			Not covered.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none">AcupunctureBariatric surgeryCosmetic surgeryDental care (Adult)Dental check-up (Child)	<ul style="list-style-type: none">Glasses (Child)Hearing aidsInfertility treatmentLong-term careNon-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">Private-duty nursingRoutine eye care (Adult)Routine foot careWeight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
<ul style="list-style-type: none">Chiropractic care (\$1,000 per calendar year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 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 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 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 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

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The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,050
- Patient pays \$2,490

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,000
Copays	\$20
Coinsurance	\$320
Limits or exclusions	\$150
Total	\$2,490

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,650
- Patient pays \$2,750

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,000
Copays	\$670
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,750

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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