Heart of Illinois Educators Association Health Benefit Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual, Family | **Plan Type:** High Deductible/Bronze Plan

This Plan is effective 9/1/15 for new hires hired on and after 8/1/15. All other employees (besides new hires) can choose this Plan Option effective 1/1/16.

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?	**$5,000** person for Preferred providers and **$10,000** person for Non-Preferred providers. Doesn't apply to outpatient pre-admission testing, outpatient emergency room (includes urgent care room in the emergency room), preferred provider and out-of-area hospital satellite urgent care clinic, second surgical opinions, and preferred provider and out-of area preventive care.	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. **$6,600** person / **$13,000** family for Preferred providers and **$13,200** person / **$26,400** family for Non-Preferred providers. Effective 1/1/16, Out-of-Pockets change as follows: **$6,850** person / **$13,700** family for Preferred providers and **$13,700** person / **$27,400** family for Non-Preferred 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, copayments (except to the extent required under the Affordable Care Act), plan exclusions 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.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See EITHER www.osfdirectaccessnetwork.com or call **1-888-209-3761 OR** www.mymethodist.net or call **1-866-510-2922** for a list of participating providers.	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

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		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**.

- **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
		Preferred / Out-of-Area Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	————none————
	OSF On-Call visit (Effective 9/1/15. Member must submit receipt to Consociate in order for $35 charge to be applied to deductible and out-of-pocket.)	$35 charge will apply towards member's deductible. If deductible has been met, charge will be subject to 20% coinsurance.	NA	
	Specialist visit	20% coinsurance	50% coinsurance	————none————
	Other practitioner office visit	20% coinsurance	50% coinsurance	————none————
	Preventive care/screening/immunization	No charge	50% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	————none————

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		Preferred / Out-of-Area Provider	Non-Preferred Provider	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-certification is required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ldirx.com.	Generic drugs	$7/prescription for 30 day supply retail; $14/prescription for 60 day supply retail and mail; $21/prescription for 90 day retail	Not covered	Covers up to a 30-day supply with a 90-day supply maximum (retail prescription); a 60-90-day supply (mail order prescription). If a patient insists on a brand name medication when there is a generic available and the physician's prescription allows for a generic to be dispensed, a penalty will be added to the applicable co-payment. This penalty is the difference in price between the brand name medication and its available generic.
	Preferred Brand drugs	20% coinsurance with $50 maximum for 30 day supply retail; 20% coinsurance with $100 maximum for 60 day supply retail and 60-90 day supply mail; 20% coinsurance with $150 maximum for 90 day supply retail		
	Non-Preferred Brand drugs	20% coinsurance with $75 maximum for 30 day supply retail; 20% coinsurance with $150 maximum for 60 day supply retail and 60-90 day supply for mail; 20% coinsurance with $225 maximum for 90 day supply retail		
	Specialty drugs	$75/prescription for 30 day supply retail	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Preferred / Out-of-Area Provider	Non-Preferred Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Pre-certification is required
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Pre-certification is required
If you need immediate medical attention	Emergency room services	$150/visit then 20% coinsurance (true emergency) or $300/visit then 20% coinsurance (non-emergency)		——————none——————
	Emergency medical transportation	20% coinsurance	50% coinsurance	——————none——————
	Urgent care	20% coinsurance	50% coinsurance	Emergency room benefits apply for urgent care room in the emergency room.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Semi-private room rate applies. Pre-certification is required.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Pre-certification is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	Pre-certification is required.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Pre-certification is required.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	Pre-certification is required.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Pre-certification is required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Pre-certification is required.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Pre-certification is required.

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Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Preferred / Out-of-Area Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Pre-certification is required.
	Rehabilitation services	20% coinsurance	50% coinsurance	Inpatient and cardiac rehabilitation – pre-certification is required.
	Habilitation services	20% coinsurance	50% coinsurance	Inpatient and cardiac rehabilitation – pre-certification is required.
	Skilled nursing care	20% coinsurance	50% coinsurance	Pre-certification is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification is required >$500
	Hospice service	20% coinsurance	50% coinsurance	Bereavement counseling is limited to 6 sessions in a 12 month period. Pre-certification is required.
If your child needs dental or eye care	Eye exam	Plan pays $200 for all vision services combined every 24 months		Exam is limited to one exam every 24 months per covered person.
	Glasses	Plan pays $200 for all vision services combined every 24 months		Frames are limited to one set of frames every 24 months. Lenses are limited to two lenses every 24 months.
	Dental check-up	No charge		Limited to $1,000 per calendar year, to include preventive, basic and major services combined.

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 excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Weight loss programs

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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.)

- Acupuncture (30 visits per calendar year, combined with chiropractic care)
- Chiropractic care (30 visit per calendar year, combined with acupuncture)
- Dental care (Adult) ($1,000 per calendar year, to include preventive, basic and major services combined)
- Hearing aids (subject to wellness benefits)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (only for patients with Type I or II Diabetes)

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?

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage meets 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** $1,390
- **Patient pays** $6,150

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	$5,000
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$150
Total	**$6,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,230
- **Patient pays** $3,170

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	$2,400
Copays	$460
Coinsurance	$230
Limits or exclusions	$80
Total	**$3,170**

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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.