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, call 1-866-375-0775 or visit us at [NOTE - insert linked to web address]. 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.cciio.cms.gov or call 1-866-375-0775 to request a copy.

### Important Questions

| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | **Yes. Preventive care.** | 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. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | **No** | You don’t have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | **Not Applicable** | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | **No** | You can see the specialist you choose without a referral. |

### Common Medical Event

<table>
<thead>
<tr>
<th><strong>Services You May Need</strong></th>
<th><strong>What You Will Pay</strong></th>
<th><strong>Limitations, Exceptions, &amp; Other Important Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td><strong>Not Covered</strong></td>
<td><strong>Not Covered – Plan limited to preventive care only.</strong></td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td><strong>Not Covered</strong></td>
<td><strong>Not Covered – Plan limited to preventive care only.</strong></td>
</tr>
<tr>
<td><strong>Preventive care/screening/ immunization</strong></td>
<td><strong>$0</strong></td>
<td><strong>Plan limited to recommended preventive care only. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</strong></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
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</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>HIV Screening</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening for Adults over 50.</td>
<td>$0</td>
</tr>
<tr>
<td>If you need contraceptive drugs</td>
<td>Generic Contraceptive drugs</td>
<td>$0 Contraceptives only</td>
</tr>
<tr>
<td>More information about prescription drug coverage</td>
<td></td>
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<tr>
<td>If you need outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Anemia screening on a routine basis for pregnant women</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**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.)

- preventive health services not meeting the requirements of the Affordable Care Act;
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- 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, and
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your **plan** document.)

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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: 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). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://www.healthcare.gov). 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:

RSL Specialty Products Administration
Toll-Free - 1-866-375-0775
Written appeals should be mailed to:
RSL Specialty Products Administration
Claims Department
505 S. Lenola Road, Suite 231
Moorstown, NJ 08057.

Department of Labor’s Employees Benefit Security Administration, Toll Free - 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

ERISA Plan Administrator:
Julie Nelson
University Payroll & Benefits
217-265-6363
By mail to:
Henry Administration Building, Room 177 (MC318)
506 S. Wright Street
Urbana, IL  61801

Additionally, a consumer assistance program can help you file your appeal. Contact:

Illinois Department of Insurance
Consumer Services Section
320 W. Washington Street, 4th Floor
Springfield, IL 62767
(866) 445-5364
http://insurance.illinois.gov/healthinsurance/consumerHealth.html (website)
DOI.Director@illinois.gov  (email)

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 the Minimum Value Standards? No
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.

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**: 100%

**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**: $12,870

In this example, Peg would pay:

- **Deductibles**: $0
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: $0

**The total Peg would pay is**: $12,600

### 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**: 100%

**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**: $7,660

In this example, Joe would pay:

- **Deductibles**: $0
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: $0

**The total Joe would pay is**: $7,050

### 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**: 100%

**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**: $2,020

In this example, Mia would pay (This condition is not covered so patient pays 100 percent):

- **Deductibles**: $0
- **Copayments**: $0
- **Coinsurance**: $0
- **What isn’t covered**: $0

**The total Mia would pay is**: $2,020

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