

state of illinois health plan members

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD. A \$50 prescription deductible applies to each plan participant (see page 20 of the State Employees Group Insurance Program FY 2012 Benefit Choice Options booklet for details).

BENEFIT	TIER I 100% Benefit	TIER II 90% Benefit	TIER III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	Not Applicable Not Applicable	\$600 \$1,200	\$1,500 \$3,500
Annual Plan Deductible <i>Must be satisfied for all services</i>	\$0	\$200 per Enrollee*	\$300 per Enrollee*
HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)			
Inpatient	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Inpatient Psychiatric	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Emergency Room <i>Waived if admitted</i>	100% after \$200 copayment per visit	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Outpatient Surgery	100% after \$175 copayment per visit	90% of network charges after \$175 copayment	80% of U&C** after \$175 copayment
Diagnostic Lab & X-Ray	100%	90% of network charges	80% of U&C**
PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)			
Physician Office Visits	100% after \$15 copayment	90% of network charges	80% of U&C**
Specialist Office Visits <i>Includes Behavioral Health providers</i>	100% after \$20 copayment	90% of network charges	80% of U&C**
Preventive Services <i>Including immunizations</i>	100%	100%	Covered under Tier I and Tier II only
Well Baby Care <i>(first year of life)</i>	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment	90% of network charges	80% of U&C**
OTHER SERVICES			
Prescription Drugs	Covered through State of Illinois administered plan, Medco; \$50 deductible applies Generic \$10 Preferred Brand \$24 Non-Preferred Brand \$48		
Durable Medical Equipment	100%	90% of network charges	80% of U&C**
Skilled Nursing Facility <i>120 days per plan year</i>	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$20 copayment	90% of network charges	Covered under Tier I and Tier II only

Please note:

* Your out-of-pocket maximum is the most you will be required to pay for any covered expenses. Plan payments do not count toward the out-of-pocket maximum. Plan copayments do not count toward the out-of-pocket maximum. Annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year.

** Covered services received from Tier III providers (out-of-network) are covered for "Usual & Customary" (U&C) charges – fees normally charged for comparable treatment in the same geographic area. Participating Tier I and Tier II physicians and facilities usually charge a lower, contracted rate for services. For more information on U&C, consult your Summary Plan Description (SPD) booklet.