

STATE OF ILLINOIS HEALTH PLAN MEMBERS

This overview is a summary only. It is subject to the benefits, exclusions, modifications and limitations contained in your Summary Plan Description (SPD) booklet.

BENEFIT	TIER I HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum Per Individual Enrollee Per Family	\$6,600 (includes eligible charges from Tier I and Tier II combined) \$13,200 (includes eligible charges from Tier I and Tier II combined)		Unlimited Unlimited
Annual Plan Deductible <i>Must be satisfied for all services</i>	\$0	\$250 per Enrollee*	\$350 per Enrollee*
HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)			
Inpatient	100% after \$350 copayment per admission	90% of network charges after \$400 copayment per admission	60% of U&C or MAC for covered services after \$500 copayment per admission**
Pre-Certification Penalty			\$500
Inpatient (Behavioral Health Services, Psychiatric)	100% after \$350 copayment per admission	90% of network charges after \$400 copayment per admission	60% of U&C or MAC for covered services after \$500 copayment per admission**
Inpatient (Behavioral Health Alcohol/Substance Abuse)	100% after \$350 copayment per admission	90% of network charges after \$400 copayment per admission	60% of U&C or MAC for covered services after \$500 copayment per admission**
Emergency Room <i>Waived if admitted</i>	100% after \$250 copayment per visit	100% after \$250 copayment per visit	100% after \$250 copayment per visit
Outpatient Surgery	100% after \$250 copayment per visit	90% of network charges after \$250 copayment	60% of U&C or MAC for covered services after \$250 copayment**
Diagnostic Lab & X-Ray	100%	90% of network charges	60% of U&C or MAC for covered services**
PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)			
Physician Office Visits	100% after \$20 copayment	90% of network charges	60% of U&C or MAC for covered services**
Specialist Office Visits <i>Includes Behavioral Health providers</i>	100% after \$30 copayment	90% of network charges	60% of U&C or MAC for covered services**
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
OTHER SERVICES			
Prescription Drugs	Prescription Drugs – Covered through State of Illinois administered plan, CVS Caremark; \$100 deductible applies Generic \$8 Preferred Brand \$26 Nonpreferred Brand \$50		
Durable Medical Equipment	80% of network charges	80% of network charges	60% of U&C or MAC for covered services**
Skilled Nursing Facility <i>120 days per plan year</i>	100% with pre-certification	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100% with pre-certification	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$30 copayment	90% of network charges	Covered under Tier I and Tier II only
Physical Therapy and Occupational Therapy <i>60 visits per plan year</i>	100% after \$30 copayment per visit with pre-certification	90% of network charges	60% of U&C or MAC for covered services**
Speech Therapy <i>60 visits per plan year</i>	100% after \$30 copayment per visit with pre-certification	90% of network charges	60% of U&C or MAC for covered services**
Hearing Exam/Aids	\$150 maximum exam and \$600 maximum aids – every 3 years, at 100%	\$150 maximum exam and \$600 maximum aids – every 3 years, deductible and co-insurance applies	\$150 maximum exam and \$600 maximum aids – every 3 years, deductible and co-insurance applies

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. 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 or amounts over the Medicare reimbursement schedule (MAC) for services rendered. 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.