HealthLink

STATE OF ILLINOIS LOCAL GOVERNMENT 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	$6,750 (includes eligible charges from Tier I and Tier II combined) $13,250 (includes eligible charges from Tier I and Tier II combined)		Unlimited Unlimited
Annual Plan Deductible *Must be satisfied for all services*	$0	$350 per Enrollee*	$550 per Enrollee*
HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)			
Inpatient	100% after $300 copayment per admission	85% after $350 copayment per admission	65% after $450 copayment per admission**
Pre-Certification Penalty			$500
Inpatient (Behavioral Health Services, Psychiatric)	100% after $300 copayment per admission	85% after $350 copayment per admission	65% after $450 copayment per admission**
Inpatient (Behavioral Health Alcohol/Substance Abuse)	100% after $300 copayment per admission	85% after $350 copayment per admission	65% after $450 copayment per admission**
Emergency Room *Waived if admitted*	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	85% after $250 copayment per visit	65% after $250 copayment per visit**
Diagnostic Lab & X-Ray Doctor's Office Facility or Lab	 100% 100%	 85% 85%	 65%** 65%**
Complex Imaging (CT/Pet Scans, MRIs)	100%	85%	65%**
PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)			
Urgent Care Services	100% after $35 copayment	85%	65%**
Physician Office Visits	100% after $35 copayment	85%	65%**
Specialist Office Visits *Includes Behavioral Health providers*	100% after $35 copayment	85%	65%**
Preventive Services *Including immunizations*	100%	100%, Deductible waived	Covered under Tier I and Tier II only
Well Baby Care *(first year of life)*	100%	100%, Deductible waived	Covered under Tier I and Tier II only
OTHER SERVICES			
Prescription Drugs	Prescription Drugs (30-day supply) – Covered through the LGHP administered plan, CVS Caremark. $150 deductible applies. Generic $13.50 Preferred Brand $27 Nonpreferred Brand $54 Specialty $108		
Durable Medical Equipment	75%	70%	65%**
Skilled Nursing Facility *120 days per plan year*	80% with pre-certification	80% with pre-certification	Covered under Tier I and Tier II only
Transplant Coverage	100% with pre-certification	90% with pre-certification	Covered under Tier I and Tier II only
Home Health Care	100% after $35 copayment	75%	Covered under Tier I and Tier II only
Physical Therapy and Occupational Therapy *60 visits per plan year*	100% after $35 copayment per visit with pre-certification	85% with pre-certification	65%** with pre-certification
Speech Therapy *60 visits per plan year*	100% after $35 copayment per visit with pre-certification	85% with pre-certification	65%** with pre-certification

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.