**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, visit www.illinois.gov/cms. 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.healthcare.gov/sbc-glossary/ or call (800) 624-2356 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0**/individual for Tier I Providers. **$250**/individual for Tier II Network Providers. **$350**/individual for Out-of-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members in this plan, they have to meet their own deductible before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care for Tier I and Tier II Network Providers. | 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/. |
| **Are there other deductibles for specific services?** | Yes. **$100**/individual for Prescription Drug. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **$6,600**/individual or **$13,200**/family for Tier I Providers and Tier II Network Providers combined. Unlimited for Out-of-Network Providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, Balance-Billing charges, and Health Care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes, HealthLink Open Access. See www.healthlink.com or call (800) 624-2356 for a list of network providers. | You pay the least if you use a provider in Tier I. You pay more if you use a provider in Tier II. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | This plan will pay some or all of the costs to see a specialist without a referral. |

* For more information about limitations and exceptions, see **plan** or policy document at https://www.illinois.gov/cms.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier I Provider (You will pay the least) | Tier II Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copayment/visit | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| | Specialist visit | $30 copayment /visit | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| | Preventive care/screening/ immunization | No charge | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) at Lab or Doctor's Office | No charge | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | No charge | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.cvs.com | Tier 1 - Typically Generic | $8 copayment /prescription (retail) and $20 copayment /prescription (mail order) | $8 copayment /prescription (retail) and $20 copayment /prescription (mail order) | See Summary Plan description | Retail is 30 day supply. Mail order is 90 day supply. See Summary Plan description. |
| | Tier 2 - Typically Preferred / Brand | $26 copayment /prescription (retail) and $65 copayment /prescription (mail order) | $26 copayment /prescription (retail) and $65 copayment /prescription (mail order) | See Summary Plan description | |
| | Tier 3 - Typically Non-Preferred / Specialty Drugs | $50 copayment /prescription (retail) and $125 copayment /prescription (mail order) | $50 copayment /prescription (retail) and $125 copayment /prescription (mail order) | See Summary Plan description | |
| | Tier 4 - Typically Specialty Drugs | Not Applicable | Not Applicable | Not Applicable | |

* For more information about limitations and exceptions, see **plan** or policy document at https://www.illinois.gov/cms

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier I Provider (You will pay the least) | Tier II Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $250 copayment /visit | $250 copayment /visit then 10% coinsurance | $250 copayment /visit then 40% coinsurance of MAC | --------none-------- |
| | Physician/surgeon fees | $30 copayment /visit | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | $250 copayment /visit | $250 copayment /visit | $250 copayment /visit | Copay waived if admitted. |
| | Emergency medical transportation | No charge | No charge | No charge | --------none-------- |
| | Urgent care | $20 copayment /visit | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $350 copayment /admission | $400 copayment /admission then 10% coinsurance | $500 copayment /admission then 40% coinsurance of MAC | --------none-------- |
| | Physician/surgeon fees | No charge | 10% coinsurance | 40% coinsurance of MAC | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit $30 copayment /visit Other Outpatient $30 copayment /visit | Office Visit 10% coinsurance Other Outpatient 10% coinsurance | Office Visit 40% coinsurance of MAC Other Outpatient 40% coinsurance of MAC | Office Visit --------none-------- Other Outpatient --------none-------- |
| | Inpatient services | $350 copayment /admission | $400 copayment /admission then 10% coinsurance | $500 copayment /admission then 40% coinsurance of MAC | --------none-------- |
| **If you are pregnant** | Office visits | $50 copayment / pregnancy | $50 copayment / pregnancy | 40% coinsurance of MAC | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | Included with Office visit copay | Included with Office visit copay | 40% coinsurance of MAC | |

* For more information about limitations and exceptions, see **plan** or policy document at https://www.illinois.gov/cms

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier I Provider (You will pay the least) | Tier II Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | $350 copayment /admission | $400 copayment /admission then 10% coinsurance | $500 copayment /admission then 40% coinsurance of MAC | |
| **If you need help recovering or have other special health needs** | Home health care | $30 copayment /visit | 10% coinsurance | Not covered | --------none-------- |
| | Rehabilitation services | $30 copayment /visit | 10% coinsurance | 40% coinsurance of MAC | See Summary Plan Description |
| | Habilitation services | $30 copayment /visit | 10% coinsurance | 40% coinsurance of MAC | |
| | Skilled nursing care | No charge | 10% coinsurance | Not covered | 120 day limit/benefit period. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 40% coinsurance of MAC | --------none-------- |
| | Hospice services | No charge | 10% coinsurance | Not covered | --------none-------- |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered | See https://www.illinois.gov/cms |
| | Children's glasses | Not covered | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | See https://www.illinois.gov/cms |

## 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.)**

- Acupuncture
- Cosmetic surgery
- Long- term care
- Dental care (adult)
- Weight loss programs
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes

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

- Hearing aids $600 maximum every 3 years.
- Pediatric hearing aids every 3 years, no dollar limit.
- Bariatric surgery
- Private-duty nursing
- Most coverage provided outside the United States
- Chiropractic care
- Infertility Treatment

* For more information about limitations and exceptions, see **plan** or policy document at https://www.illinois.gov/cms

**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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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:

HealthLink Grievances and Appeals, P.O. Box 411424 St. Louis, MO 63141-1424

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

**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? Yes**

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.*

* For more information about limitations and exceptions, see **plan** or policy document at https://www.illinois.gov/cms

## 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* | $50 |
| Hospital (facility) *copayment* | $350 |
| Other *coinsurance* | 0% |

**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** | **$12,840** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$460** |

### 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* | $30 |
| Hospital (facility) *copayment* | $350 |
| Other *coinsurance* | 0% |

**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** | **$7,460** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $585 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$740** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *copayment* | $30 |
| Hospital (facility) *copayment* | $350 |
| Other *coinsurance* | 0% |

**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** | **$2,010** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $340 |
| Coinsurance | $160 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |

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

## Language Access Services:

**(TTY/TDD: 711)**

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 624-2356

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (800) 624-2356

**Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電** (800) 624-2356.。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 624-2356로 문의하십시오.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 624-2356

**Arabic** (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 624-2356.

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 624-2356

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 624-2356

**Urdu** (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (800) 624-2356. پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (800) 624-2356

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 624-2356

## Language Access Services:

**Hindi** (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 624-2356. ।

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 624-2356

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 624-2356

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 624-2356

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That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.