



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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 624-2356 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$0</b> /individual for Tier I <a href="#">Providers</a> . <b>\$300</b> /individual for Tier II <a href="#">Network Providers</a> . <b>\$400</b> /individual for Out-of- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">deductible</a> before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> for Tier I and Tier II <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$6,600</b> /individual or <b>\$13,200</b> /family for Tier I <a href="#">Providers</a> and Tier II <a href="#">Network Providers</a> combined. Unlimited for Out-of- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">Balance-Billing</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, HealthLink Open Access. See <a href="http://www.healthlink.com">www.healthlink.com</a> or call (800) 624-2356 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Tier I. You pay more if you use a <a href="#">provider</a> in Tier II. You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> without a <a href="#">referral</a> .

\* 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 copayment/visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
	<a href="#">Specialist</a> visit	\$20 copayment /visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work) at Lab or Doctor's Office	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cvs.com">www.cvs.com</a>	Tier 1 - Typically Generic	\$10 copayment /prescription (retail) and \$20 copayment /prescription (mail order)	\$10 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	\$20 copayment /prescription (retail) and \$40 copayment /prescription (mail order)	\$20 copayment /prescription (retail) and \$40 copayment /prescription (mail order)	See Summary Plan description	
	Tier 3 - Typically Non-Preferred / <a href="#">Specialty Drugs</a>	\$40 copayment /prescription (retail) and \$80 copayment /prescription (mail order)	\$40 copayment /prescription (retail) and \$80 copayment /prescription (mail order)	See Summary Plan description	
	Tier 4 - Typically <a href="#">Specialty Drugs</a>	Not Applicable	Not Applicable	See Summary Plan description	

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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)	\$150 copayment /visit	\$150 copayment /visit then 20% <a href="#">coinsurance</a>	\$150 copayment /visit then 40% <a href="#">coinsurance</a> of MAC	-----none-----
	Physician/surgeon fees	\$20 copayment /visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 copayment /visit	\$200 copayment /visit	Covered as In- <a href="#">Network</a>	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	No charge	-----none-----
	<a href="#">Urgent care</a>	\$20 copayment /visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copayment /admission	\$300 copayment /admission then 20% <a href="#">coinsurance</a>	\$400 copayment /admission then 40% <a href="#">coinsurance</a> of MAC	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20 copayment /visit Other Outpatient \$20 copayment /visit	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> of MAC Other Outpatient 40% <a href="#">coinsurance</a> of MAC	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$250 copayment /admission	\$300 copayment /admission then 20% <a href="#">coinsurance</a>	\$400 copayment /admission then 40% <a href="#">coinsurance</a> of MAC	-----none-----
If you are pregnant	Office visits	\$50 copayment / pregnancy	\$50 copayment / pregnancy	40% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> of MAC	

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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	\$250 copayment /admission	\$300 copayment /admission then 20% <a href="#">coinsurance</a>	\$400 copayment /admission then 40% <a href="#">coinsurance</a> of MAC	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$15 copayment /visit	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	\$20 copayment /visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	Precertification required. See Summary Plan Description
	<a href="#">Habilitation services</a>	\$20 copayment /visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	120 day limit/benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of MAC	-----none-----
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	-----none-----
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Not covered	See <a href="https://www.illinois.gov/cms">https://www.illinois.gov/cms</a>
	Children’s glasses	Not covered	Not covered	Not covered	
	Children’s dental check-up	Not covered	Not covered	Not covered	See <a href="https://www.illinois.gov/cms">https://www.illinois.gov/cms</a>

**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](#).)**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Long- term care</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Weight loss programs</li> <li>• Routine eye care (adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care unless you have been diagnosed with diabetes</li> <li>• Hearing aids</li> </ul> |
|--|---|--|

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

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Most coverage provided outside the United States</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Chiropractic care</li> </ul> |
|---|--|--|

**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](http://www.dol.gov/ebsa/healthreform). Other

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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](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:

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](http://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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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\* 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$360</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$690
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$745</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$460</b>

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

### It's important we treat you fairly

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>.