
 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.lineco.org](http://www.lineco.org) or call 1-800-323-7268. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-323-7268 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$400 per person / \$1,200 per family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> provided by a <a href="#">network provider</a> is covered before you meet your <a href="#">deductible</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 <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes, \$250 for hospital review program non-compliance and \$150 for emergency room visits. 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 plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,625 per person / \$7,500 per family for medical and \$1,000 per person / \$2,000 per family for prescription drugs	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> . For mental health/substance abuse see <a href="http://www.beaconhealthoptions.com/">www.beaconhealthoptions.com/</a> or call Beacon Health Option at 1-(800)-332-2191.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's 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 <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	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% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	None.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge for first \$150 per year, 20% <a href="#">coinsurance</a> * thereafter	No charge for first \$150 per year, 30% <a href="#">coinsurance</a> thereafter	The \$150 benefit applies to employees and spouses only.
	Imaging (CT/PET scans, MRIs)			
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.express-scripts.com">www.express-scripts.com</a>	Generic drugs	20% <a href="#">coinsurance</a> retail, \$10 <a href="#">copayment</a> mail	20% <a href="#">coinsurance</a>	Drug benefits provided through an enhanced Part D plan; certain clinical management programs may apply.
	Preferred brand drugs	20% <a href="#">coinsurance</a> retail, \$20 <a href="#">copayment</a> mail	20% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	20% <a href="#">coinsurance</a> retail, \$35 <a href="#">copayment</a> mail	20% <a href="#">coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	Pre-certification and in-network providers required for bariatric & TMJ surgery or services are not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> *	20% <a href="#">coinsurance</a>	An additional \$150 <a href="#">deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> *	20% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	None.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.lineco.org](http://www.lineco.org).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	An additional \$250 <a href="#">deductible</a> applies if inpatient confinement not <a href="#">preauthorized</a> . <a href="#">Preauthorization</a> and <a href="#">network provider</a> required for bariatric & TMJ surgery or services are not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> * Primary network is through BeaconHealth Options	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for intensive outpatient treatment, psychological testing, electroconvulsive therapy, ABA therapy or services are not covered.
	Inpatient services	20% <a href="#">coinsurance</a> * Primary network is through BeaconHealth Options	30% <a href="#">coinsurance</a>	An additional \$250 <a href="#">deductible</a> applies if inpatient confinement not <a href="#">preauthorized</a> . <a href="#">Preauthorization</a> is required for inpatient, residential and partial inpatient treatment and electroconvulsive therapy, ABA therapy, or services are not covered.
If you are pregnant	Office visits	No charge	30% <a href="#">coinsurance</a>	Maternity benefits are not provided for covered dependent children (other than prenatal visits).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	Coverage is limited to 40 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	The allowable amount for speech therapy is \$90 per visit, and the plan allows 50 visits per year maximum.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	Coverage is limited to 30-day annual maximum.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a>	Coverage is limited to 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	<a href="#">Network provider</a> is Vision Service Plan. The Plan provides covered exams and contracted eyewear.	Amount over \$35	You pay for <a href="#">network provider</a> upgrades.
	Children's glasses		Amount over \$35 for frame and over \$30 for lenses	
	Children's dental check-up	No charge	No charge	None.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.lineco.org](http://www.lineco.org).]

\*The 20% [network provider coinsurance](#) only applies when LINECO is the person's primary plan. When Medicare is primary, the [network provider coinsurance](#) does not apply.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services, except for speech therapy for children for treatment of congenital medical defects and acute diseases, including hearing deficits caused by specifically diagnosed illnesses, cerebral palsy, and neurological disorders including autism</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul>
<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture up to 12 visits per year</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery if pre-certified (only one per lifetime and not covered for children)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care, subject up to \$600 annual maximum for all spinal manipulations/adjustments (and related services)</li> </ul>
<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids up to \$2,500 (bilateral) every 5 years (every 2 years for children)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</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 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://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](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: 1-800-323-7268.

**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](#).

[\* For more information about limitations and exceptions, see the plan or policy document at [www.lineco.org](http://www.lineco.org).]

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-323-7268.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-323-7268.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-323-7268.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-323-7268.]

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

## 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](#) \$400
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$0
Coinsurance	\$1,630
<i>What isn't covered</i>	
Limits or exclusions*	\$720
<b>The total Peg would pay is</b>	<b>\$2,750</b>

\*Genetic tests and OTC products are excluded.

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$150
Coinsurance	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$820</b>