Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 07/01/2023 - 06/30/2024**

State of Illinois: LGHP

Coverage for: Individual + Family | **Plan Type:** HMO

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, www.healthalliance.org/stateofillinois or call 1-800-851-3379. 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 https://www.healthalliance.org/documents/1492 or call 1-800-851-3379 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	
Are there other deductibles for specific services?	Yes; $175 Prescription Drugs per Individual.	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?	$3,000 Individual/ $6,000 Family	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, healthcare this plan does not 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. See: www.healthalliance.org/stateofillinois or call 1-800-851-3379 for a list of Participating (In-network) providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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?	Yes, this plan may require referrals to in-network specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Participating (In-Network) Provider (You will pay the least)	Non-Participating (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	$40 copay/visit	Not Covered	--none--
	Specialist visit	$45 copay/visit	Not Covered	--none--
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what you plan will pay for. Refer to Wellness Brochure.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/service	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	$0 copay/service	Not Covered	Preauthorization Required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://healthalliance.org /documents/formulary/6 61/2023	Reduced Generic Tier 1	$4 copay / prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.5 copays.
	Generic Tier 1	$15 copay / prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.5 copays.
	Preferred Brand Tier 2	$30 copay / prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.5 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.

	Non-Preferred Brand Tier 3	$60 copay / prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.5 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand **Deductible**, **Copayment** and/or **Coinsurance**, plus a 100% **coinsurance** for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your **Deductible**. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Specialty Tier 4	$120 copay / prescription	Not Covered	**Preauthorization** may be required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand **Deductible**, **Copayment** and/or **Coinsurance**, plus a 100% **coinsurance** for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your **Deductible**. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay/procedure	Not Covered	**Preauthorization** may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	No Charge	Not Covered	--none--

Common Medical Event	Services You May Need	What You Will Pay Participating (In-Network) Provider (You will pay the least)	 Non-Participating (Out of Network) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	**Emergency room care**	$300 copay / visit	$300 copay / visit	Participating Benefit Applies
	Emergency medical transportation	No Charge	No Charge	Participating Benefit Applies
	Urgent care	$40 copay / visit	$40 copay/visit	--none--
If you have a hospital stay	Facility fee (e.g., hospital room	$350 copay / stay	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	No Charge	Not Covered	**Preauthorization** may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit	Not Covered	--none--
	Inpatient services	$350 copay / stay	Not Covered	**Preauthorization** is required.
If you are pregnant	Office visits	$50 copay/pregnancy	Not Covered	--none--
	Childbirth/delivery professional services	No Charge	Not Covered	--none--
	Childbirth/delivery facility services	$350 copay / stay	Not Covered	--none--
If you need help recovering or have other special health needs	**Home health care**	$45 copay/visit	Not Covered	--none--
	Rehabilitation services	$40 copay/visit	Not Covered	**Preauthorization** is required. 60 visits per condition per plan year maximum.
	Habilitation services	$40 copay/visit	Not Covered	60 visits per condition per plan year maximum.
	Skilled nursing care	$0 copay / stay	Not Covered	**Preauthorization** is required.
	Durable medical equipment	30% coinsurance	Not Covered	**Preauthorization** may be required for certain medical equipment. Contact Customer Service for detailed information.
	Hospice services	$0 copay	Not Covered	--none--
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	--none--
	Children's glasses	Not Covered	Not Covered	--none--
	Children's dental check-up	Not Covered	Not Covered	--none--

* For more information about limitations and exceptions, see the plan or policy document at www.healthalliance.org/stateofillinois.

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.)

- Cosmetic Surgery(limited)
- Long-Term Care
- Weight Loss Programs
- Non-Emergency Care When Traveling Outside the U.S.
- Routine eye Care

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

- Bariatric Surgery
- Chiropractic Care
- Elective Abortion
- Hearing Aids – Limited to $5,000 (total) ($2,500 per each ear)
- Infertility Services
- Routine foot care
- Acupuncture

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: For group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

For non-federal governmental group health plans and church plans that are group health plans, contact Health Alliance at 1-800-851-3379 and State of Illinois Department of Insurance at 1-877-527-9431 or **consumer_complaints@ins.state.il.us**.

Additionally, a consumer assistance program can help you file your **appeal**. Contact 1-800-851-3379. A list of states with Consumer Assistance Programs is available at: **www.dol.gov/ebsa/healthreform** and **http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/**.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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**.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-851-3379.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-851-3379.
Chinese (中文): 如果需要中文的帮助，⊠⊠打⊠个号⊠1-800-851-3379.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-851-3379.

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

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 $45 copay/visit**
- **Hospital (facility) $350 copay/stay**
- **Other 0% coinsurance**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$410**

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 $45 copay/visit**
- **Hospital (facility) $350 copay/stay**
- **Other 0% coinsurance**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$810**

Mia's Simple Fracture

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

- **The plan's overall deductible $0**
- **Specialist $45 copay/visit**
- **Hospital (facility) $350 copay/stay**
- **Other 0% coinsurance**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$650
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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

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