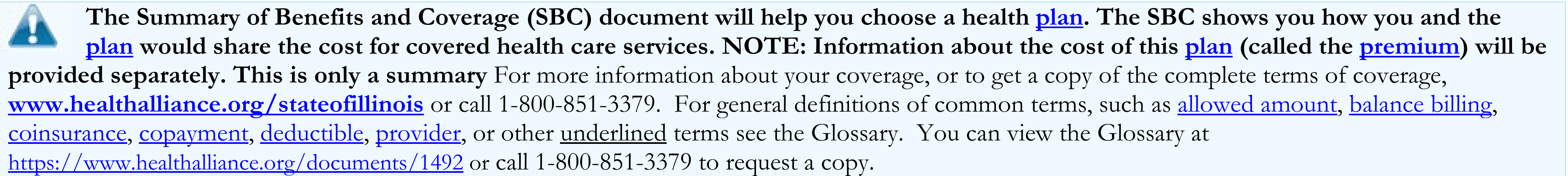
Health Alliance

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 07/01/2021 - 06/30/2022**

State of Illinois: CIP

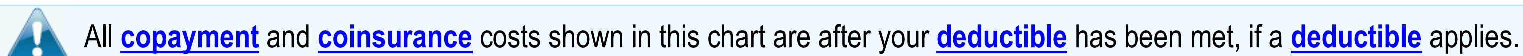
Coverage for: Individual + Family | **Plan Type:** HMO



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?	No.	You don't have to meet deductibles for specific 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, 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).
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: Participating (In-Network) Provider (You will pay the least)	What You Will Pay: Non-Participating (Out of Network) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not Covered	--none--
	Specialist visit	$30 copay/visit	Not Covered	--none--
	Preventive care/screening/ immunization	No Charge	Not Covered	Refer to Wellness Brochure
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	0% coinsurance	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/661/2021	Reduced Generic Tier 1	$4 copay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Generic Tier 1	$12 copay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Preferred Brand Tier 2	$24 copay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Non-Preferred Brand Tier 3	$48 copay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Specialty Tier 4	$96 copay / prescription	Not Covered	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/surgery	Not Covered	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	No Charge	Not Covered	--none--
If you need immediate medical attention	Emergency room care	$200 copay / visit	$200 copay / visit	Participating Benefit Applies
	Emergency medical transportation	No Charge	No Charge	Participating Benefit Applies
	Urgent care	$30 copay / visit	$30 copay / visit	--none--

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

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 have a hospital stay	Facility fee (e.g., hospital room)	$250 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	$30 copay/visit	Not Covered	--none--
	Inpatient services	$250 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	$250 copay / stay	Not Covered	--none--
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	Not Covered	--none--
	Rehabilitation services	$30 copay/visit	Not Covered	Preauthorization is required. 60 visits per condition per plan year maximum.
	Habilitation services	$30 copay/visit	Not Covered	See rehabilitation visit maximum.
	Skilled nursing care	$0 copay / stay	Not Covered	Preauthorization is required.
	Durable medical equipment	20% 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--

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(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

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

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.

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 $30 copay/visit**
- **Hospital (facility) $250 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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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 $30 copay/visit**
- **Hospital (facility) $250 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	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

- **The plan's overall deductible $0**
- **Specialist $30 copay/visit**
- **Hospital (facility) $250 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	$700
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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

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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801, telephone for membersin Illinois, Indiana, Iowa and Ohio: (800) 851-3379; members in Washington call: (877) 750-3515 (TTY: 711), fax: (217) 902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office forCivil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington,DC 20201, (800) 368-1019 (TTY: (800) 537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA,IL, IN, OH: Llame (800) 851-3379, WA Llame: (877) 750-3515 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 (800) 851-3379, WA: 呼叫 (877) 750-3515（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 851-3379, WA: Zadzwoń (877) 750-3515 (TTY: 711).

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انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 3379-851 (800)، ولاية واشنطن:اتصل بالرقم: 3515-750 (877) (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH:Anruf (800) 851-3379, WA: Anruf (877) 750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA,IL, IN, OH: Appelez (800) 851-3379, WA: Appelez (877) 750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ (800) 851-3379,WA: કૉલ (877) 750-3515 (TTY: 711).

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LET OP: Services Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA:Call (877) 750-3515 (TTY: 711).

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