
 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 , 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 .

<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See: www.healthalliance.org/stateofillinois or call 1-800-851-3379 for a list of <u>Participating (In-network) providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>Yes, this <u>plan</u> may require <u>referrals</u> to in-network <u>specialists</u>.</p>	<p>This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u>.</p>

 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	\$30 copay /visit	Not Covered	--none--
	Specialist visit	\$30 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/661/2023	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	\$12 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	\$24 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.

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

	Non-Preferred Brand Tier 3	\$48 <u>copay</u> / 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 <u>Deductible</u> , <u>Copayment</u> and/or <u>Coinsurance</u> , plus a 100% <u>coinsurance</u> for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your <u>Deductible</u> . In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Specialty Tier 4	\$96 <u>copay</u> / prescription	Not Covered	<u>Preauthorization</u> 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 <u>Deductible</u> , <u>Copayment</u> and/or <u>Coinsurance</u> , plus a 100% <u>coinsurance</u> for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your <u>Deductible</u> . 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)	\$200 <u>copay</u> /procedure	Not Covered	<u>Preauthorization</u> 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		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 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--
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	60 visits per condition per plan year 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--

* 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
- Non-Emergency Care When Traveling Outside the U.S.
- Weight Loss Programs
- 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
- Hearing Aids – Limited to \$5,000 (total) (\$2,500 per each ear)
- Routine foot care
- Chiropractic Care
- Infertility Services
- Acupuncture
- Elective Abortion

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, 请拨打个号 1-800-851-3379.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$760

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,300

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$540

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<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). Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi (800) 851-3379, WA: Gọi (877) 750-3515 (TTY: 711). 주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 851-3379 IA, IL, IN, OH: 전화 WA: (877) 750-3515 전화 (TTY: 711). ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 851-3379, WA: Вызов (877) 750-3515 (TTY: 711). Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag (800) 851-3379, WA: Tumawag (877) 750-3515 (TTY: 711). إذا كنت تكلم كنت إذا

3379- مجاناً لك متوفرة المساعدة خدمات فإن، إننا لمينوي . انتباه: واشنطن ولة)، 800 (851 إذا) 877 (750-3515: بالرقم اتصل بالرقم اتصل: أوهايو فاتصل السمعي صة أو الصمم من تعني كنت (Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistentendienste 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). ध्यान: तमेवलत तले गजराती, भाषा सहाय सेवामे, मफत, तमारि माटेउपवस्य छे. IA, IL, IN, OH: कोल (800) 851-3379, WA: कोल (877) 750-3515 (TTY: 711). 注意：あなたは、日本語、無料で言語支援サービスを、話す場合は、あなたに利用可能です。(800) 851-3379 IA, IL, IN, OH: コール (877) 750-3515 WA: コール (TTY: 711)。 LET OP: Services Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711). УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик (800) 851-3379, WA: Виклик (877) 750-3515 (TTY: 711). ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare (800) 851-3379, WA: Chiamare (877) 750-3515 (TTY: 711).