# 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 www.healthalliance.org 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 | | 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 co-pay/visit | Not Covered | --none-- |
| | Specialist visit | $30 co-pay/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% co-insurance | Not Covered | --none-- |
| | Imaging (CT/PET scans, MRIs) | 0% co-insurance | Not Covered | Preauthorization Required |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.healthalliance.org/stateofillinois** | Reduced Generic Tier 1 | $4 co-pay / prescription | Not Covered | Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays. |
| | Generic Tier 1 | $12 co-pay / prescription | Not Covered | Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays. |
| | Preferred Brand Tier 2 | $24 co-pay / prescription | Not Covered | Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays. |
| | Non-Preferred Brand Tier 3 | $48 co-pay / prescription | Not Covered | Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays. |
| | Specialty Tier 4 | $96 co-pay / prescription | Not Covered | Preauthorization is required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $200 co-pay/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 co-pay / visit | $200 co-pay / visit | Participating Benefit Applies |
| | Emergency medical transportation | No Charge | No Charge | Participating Benefit Applies |
| | Urgent care | $30 co-pay / visit | Not Covered | --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 co-pay / 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 co-pay/visit | Not Covered | --none-- |
| | Inpatient services | $250 co-pay / stay | Not Covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | $50 co-pay/pregnancy | Not Covered | --none-- |
| | Childbirth/delivery professional services | No Charge | Not Covered | --none-- |
| | Childbirth/delivery facility services | $250 co-pay / stay | Not Covered | --none-- |
| **If you need help recovering or have other special health needs** | Home health care | $30 co-pay/visit | Not Covered | Preauthorization is required. |
| | Rehabilitation services | $30 co-pay/visit | Not Covered | Preauthorization is required. 60 visits per condition per plan year maximum. |
| | Habilitation services | $30 co-pay/visit | Not Covered | See rehabilitation visit maximum. |
| | Skilled nursing care | $0 co-pay / stay | Not Covered | Preauthorization is required. |
| | Durable medical equipment | 20% co-insurance | Not Covered | Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information. |
| | Hospice services | $0 co-pay | 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

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

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric Surgery<br>• Chiropractic Care<br>• Elective Abortion | • Hearing Aids – Limited to $5,000 (total) ($2,500 per each ear)<br>• 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，请拨打这个号码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 co-pay/visit**
- **Hospital (facility) $250 co-pay/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** | **$12,731** |
|---|---|

**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 co-pay/visit**
- **Hospital (facility) $250 co-pay/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** | **$7,390** |
|---|---|

**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 co-pay/visit**
- **Hospital (facility) $250 co-pay/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** | **$1,900** |
|---|---|

**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** |

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

Health Alliance Medical Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans:

- 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
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If you need these services, contact customer service.

If you believe that Health Alliance Medical Plans 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 Medical Plans, Customer Service, 301 South Vine, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711 or 1-800-526-0844, fax: 217-365-7494, 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 for Civil 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, 1-800-868-1019, 800-537-7697 (TDD).

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

**Language Access Services:**

**English:**
If you, or someone you're helping, has questions about Health Alliance Medical Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-851-3379.

**Spanish:**
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Health Alliance Medical Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-851-3379.

**Polish:**
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Health Alliance Medical Plans, masz prawo do uzyskania bezpłatnej informacji I pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-851-3379.

**Chinese:**
如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Health Alliance Medical Plans,]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-851-3379

**Korean:**
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health Alliance Medical Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-851-3379 로 전화하십시오.

**Tagalog:**
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health Alliance Medical Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-851-3379.

**Arabic:**
أســـئلة تســـاعده شـخص لـدى أو لـــديك كـان إن بخصـــوص Health Alliance Medical Plans المســـاعدة علـى الحصـــول فـــي الحـق فلـــديك والمعلومـــات
تكلفـــــة ايـة دون من بلغتـــــك الضـــرورية.
ب تصـــلا مـترجم مع للتحـــدث 1-800-851-3379.

**Russian:**
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health Alliance Medical Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-851-3379.

**Gujarati:**
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ થી કોઇને [એસબીએમ કાર્યક્રમન ાં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર ] પર કોલ કરો. 1-800-851-3379.

**Urdu:**
دونـوں اپ اور ہیـں رہے دے مدد کـو ی کـس اپ اگـر ہے سـوال کـو Health Alliance Medical Plans, زبـان ی اپـن کـو دونـوں اپ تـو ،میـں بـارے کـے حق کـا کـرنے حاصـل معالومـات اور مدد مفـت میـں لیـے کـے کـرنے بـات سـے ترجمـان ہے، 1-800-851-3379 کـریں فـون.

**Vietnamese:**
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Alliance Medical Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-851-3379.

**Italian:**
Se tu o qualcuno che stai aiutando avete domande su Health Alliance Medical Plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-851-3379.

**Hindi:**
यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Health Alliance Medical Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के लिए 1-800-851-3379 पर कॉि करें।

**French:**
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health Alliance Medical Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-851-3379.

**Greek:**
Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Health Alliance Medical Plans, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-851-3379.

**German:**
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Alliance Medical Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-851-3379.