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 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**	Preferred Formulary Generic drugs	$12 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays.
	Preferred Formulary brand drugs	$24 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays.
	Non-preferred Formulary brand drugs	$48 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 co-pays.
	Preferred Formulary (Tier 4) Specialty drugs	$96 co-pay / prescription	Not Covered	Preauthorization is required.
	Non-Preferred Formulary (Tier 5) Specialty drugs	$96 co-pay / prescription	Not Covered	Preauthorization is required.
	Non-Formulary (Tier 6) Specialty drugs	$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)
- Hearing Aids
- 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		
• Chiropractic Care	• 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.

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 1-866-247-3296.

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 1-866-247-3296.

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 1-866-247-3296.

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 1-866-247-3296。

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 1-866-247-3296 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 1-866-247-3296.

Arabic:

أسئلة تساعده شخص لدى أو لديك كان إن بخصوص Health Alliance Medical Plans المساعدة على الحصول في الحق فلديك معلوماتوال تكلفة اية دون من بلغتك الضرورية. ب اتصل مترجم مع للتحدث 1-866-247-3296.

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 телефону1-866-247-3296.

Gujarati:

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને [એસબીએમ ક ર્યક્રમન ાં 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. 1-866-247-3296.

Urdu:

دونوں اپ اور ہیں رہے دے مدد کو یکس اپ اگر ہے سوال کو Health Alliance Medical Plans, زبان یاپن کو دونوں اپ تو ،میں بارے کے

حق کا کرنے حاصل اتمعالوم اور مدد مفت میں
لیے کے کرنے بات سے ترجمان ہے، 1-
866-247-3296 فون کریں۔

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 1-866-247-3296.

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 1-866-247-3296.

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 1-866-247-3296 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 1-866-247-3296.

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 1-866-247-3296.

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 1-866-247-3296.