



# State of Illinois: State Plan

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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	
Are there other <a href="#">deductibles</a> for specific services?	Yes; \$150 Prescription Drugs	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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 Individual/ \$6,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See: <a href="http://www.healthalliance.org/stateofillinois">www.healthalliance.org/stateofillinois</a> 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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>Yes, this plan may require referrals to in-network specialists.</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 specialist.</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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <b>copay</b> /visit	Not Covered	--none--
	<a href="#">Specialist</a> visit	\$35 <b>copay</b> /visit	Not Covered	--none--
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No Charge	Not Covered	Refer to Wellness Brochure
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <b>coinsurance</b>	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	\$30 <b>copay</b> /service	Not Covered	Preauthorization Required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://healthalliance.org/documents/formulary/61/2021">prescription drug coverage</a> is available at <a href="https://healthalliance.org/documents/formulary/61/2021">https://healthalliance.org/documents/formulary/61/2021</a>	Reduced Generic Tier 1	\$4 <b>copay</b> / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Generic Tier 1	\$13 <b>copay</b> / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Preferred Brand - Preferred Specialty Tier 2	\$31 <b>copay</b> / prescription	Not Covered	Covers up to a 30-day supply; 90 day supply available for 2.5 copays.
	Non-Preferred Brand - Non-Preferred Specialty Tier 3	\$55 <b>copay</b> / prescription	Not Covered	Preauthorization is required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 <b>copay</b> /surgery	Not Covered	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	No Charge	Not Covered	--none--
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$275 <b>copay</b> / visit	\$275 <b>copay</b> / visit	Participating Benefit Applies
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Participating Benefit Applies
	<a href="#">Urgent care</a>	\$30 <b>copay</b> / visit	\$30 <b>copay</b> / visit	--none--
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400 <b>copay</b> / stay	Not Covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization may be required.

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthalliance.org/stateofillinois](https://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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> /visit	Not Covered	--none--
	Inpatient services	\$400 <u>copay</u> / stay	Not Covered	Preauthorization is required.
<b>If you are pregnant</b>	Office visits	\$50 <u>copay</u> /pregnancy	Not Covered	--none--
	Childbirth/delivery professional services	No Charge	Not Covered	--none--
	Childbirth/delivery facility services	\$400 <u>copay</u> / stay	Not Covered	--none--
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$35 <u>copay</u> /visit	Not Covered	--none--
	<a href="#">Rehabilitation services</a>	\$35 <u>copay</u> /visit	Not Covered	Preauthorization is required. 60 visits per condition per plan year maximum.
	<a href="#">Habilitation services</a>	\$35 <u>copay</u> /visit	Not Covered	See rehabilitation visit maximum.
	<a href="#">Skilled nursing care</a>	\$0 <u>copay</u> / stay	Not Covered	Preauthorization is required.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	<a href="#">Hospice services</a>	\$0 <u>copay</u>	Not Covered	--none--
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery(limited)</li> </ul>	<ul style="list-style-type: none"> <li>Long-Term Care</li> <li>Weight Loss Programs</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency Care When Traveling Outside the U.S.</li> <li>Routine eye Care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Chiropractic Care</li> <li>Elective Abortion</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids – Limited to \$5,000 (total) (\$2,500 per each ear)</li> <li>Infertility Services</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthalliance.org/stateofillinois](http://www.healthalliance.org/stateofillinois).

**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](http://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](http://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](http://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](mailto: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](http://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, kwijigo 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](#) \$35 [copay/visit](#)
- Hospital (facility) \$400 [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$11
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$571</b>

### 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](#) \$35 [copay/visit](#)
- Hospital (facility) \$400 [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$800
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$1,250</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) \$35 [copay/visit](#)
- Hospital (facility) \$400 [copay/stay](#)
- Other 0% [coinsurance](#)

400

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1000
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</b>

## **DISCRIMINATION IS AGAINST THE LAW**

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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 members in Illinois, Indiana, Iowa and Ohio: (800) 851-3379; members in Washington call: (877) 750-3515 (TTY: 711), fax: (217) 902-9705, [CustomerService@healthalliance.org](mailto: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 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, (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:** 당신 이 한국어, 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).

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

**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:** तमे वात ती गुजराती, भाषा सहाय सेवायो, मुफ्त, तमारी माटे उपलब्ध छे. IA, IL, IN, OH: कॉल (800) 851-3379, WA: कॉल (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)] schwetzsch, kannst 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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