HMO 4500 Elite Silver

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthalliance.org or by calling 1-800-851-3379.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$4,500 Individual/$9,000 Family. Doesn't apply to Office Visits, Urgent Care Visits, Spinal Manipulations, Prescription Drugs, Pediatric Dental Exam, Pediatric Vision Care, Pediatric Vision Materials and Preventive Services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	$6,500 Individual/$13,000 Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-800-851-3379 or visit us at www.healthalliance.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.healthalliance.org or call 1-800-851-3379 to request a copy.

Does this plan use a network of providers?	Yes. For a list of **In-network Providers**, see www.healthalliance.org or call 1-800-851-3379.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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	$60 co-pay/visit	Not Covered	--none--
	Other practitioner office visit	$60 co-pay/visit for chiropractic spinal manipulations	Not Covered	Preauthorization is required. 25 visits per plan year.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to Wellness Brochure.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	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.	Preferred Formulary Generic drugs	$7 co-pay/ prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Preferred Formulary brand drugs	$35 co-pay/ prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Non-preferred Formulary brand drugs	$70 co-pay/ prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Preferred Formulary (Tier 4) Specialty drugs	50% coinsurance	Not Covered	Preauthorization is required.
	Non-Preferred Formulary (Tier 5) Specialty drugs	50% coinsurance	Not Covered	Preauthorization is required.
	Non-Formulary (Tier 6) Specialty drugs	50% coinsurance	Not Covered	Preauthorization is required.
	Preventive drugs (Tier 7)	No Charge	Not Covered	--none--
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	20% coinsurance	Not Covered	--none--
If you need immediate medical	Emergency room services	20% coinsurance	20% coinsurance	Participating Benefit Applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Participating Benefit Applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
attention	Urgent care	$60 co-pay/visit	$60 co-pay/visit	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	--none--
	Physician/surgeon fee	20% coinsurance	Not Covered	--none--
If you have mental health, behavioral health, or substance use needs	Mental/Behavioral health outpatient services	$30 co-pay/visit	Not Covered	--none--
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	--none--
	Substance use disorder outpatient services	$30 co-pay/visit	Not Covered	--none--
	Substance use disorder inpatient services	20% coinsurance	Not Covered	--none--
If you are pregnant	Prenatal and postnatal care	20% coinsurance for routine prenatal care	Not Covered	--none--
	Delivery and all inpatient services	20% coinsurance	Not Covered	--none--
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	20% coinsurance	Not Covered	60 visits per condition per plan year.
	Habilitation services	20% coinsurance	Not Covered	See rehabilitation visit maximum.
	Skilled nursing care	20% coinsurance	Not Covered	--none--
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for more information.
	Hospice service	20% coinsurance	Not Covered	--none--
If your child needs dental or eye care	Eye exam	$0 co-pay/exam	Not Covered	One routine eye exam per plan year.
	Glasses	$0 co-pay/item	Not Covered	One item per plan year.
	Dental check-up	$0 co-pay/exam	Not Covered	One exam every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Long-term care
- Cosmetic surgery (Limited)
- Non-Emergency Care When Traveling Outside the U.S.
- Dental care (Adult)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Hearing aids (Pediatric)
- Private-Duty Nursing
- Chiropractic care
- Infertility services
- Routine eye care (Adult)
- Cochlear implants
- Routine foot care
- Temporomandibular Joint (TMJ) treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-851-3379. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Alliance at 1-800-851-3379. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Illinois Department of Insurance at 1-877-850-4740 or www.ins.state.il.us.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."

This plan or policy does provide minimum essential coverage.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,330
- **Patient pays** $5,210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,500
Copays	$10
Coinsurance	$500
Limits or exclusions	$200
Total	**$5,210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,210
- **Patient pays** $1,280

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$700
Copays	$500
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,280**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

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

Spanish

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-851-3379 (TTY: 711).

Chinese

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫1-800-851-3379（TTY: 711）。

Polish

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-851-3379 (TTY: 711).

Vietnamese

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-851-3379 (TTY: 711).

Korean

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 전화 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-851-3379 (TTY: 711).

Tagalog

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-851-3379 (TTY: 711).

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء1-800-851-3379 (TTY: 711).

German

Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. Anruf 1-800-851-3379 (TTY: 711).

French

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-851-3379 (TTY: 711).

Gujarati

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 1-800-851-3379 (TTY: 711).

Japanese

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。 1-800-851-3379**コール**（TTY: 711）。

Pennsylvania Dutch

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-851-3379 (TTY: 711).

Ukrainian

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-851-3379 (TTY: 711).

Italian

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