Simplete Memorial HMO 2000 Gold

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, [insert contact information]. 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?	$2,000 Individual/$4,000 Family In-Network Participating Provider $3,500 Individual/$7,000 Family In-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative/Wellness, Primary Care Visits, Specialty Visits, Urgent Care, Emergency Room Visits, Diagnostic Testing, Mental Health/Substance Use Visits Prescription Drugs, and Pediatric Eye Care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$4,000 Individual/ $8,000 Family For In-network Participating Providers $7,900 Individual/ $15,800 Family For In-network Providers	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, Out of Network Precert Penalties.	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: https://www.healthalliance.org/Guests/ProviderSearch/q?Criteria.DirectoryName=S01 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
		In-Network Participating Provider	In-Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 co-pay/visit	$25 co-pay/visit	Not Covered	--none--
	Specialist visit	$35 co-pay/visit	$35 co-pay/visit	Not Covered	--none--
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	Refer to Wellness Brochure
If you have a test	Diagnostic test (x-ray, blood work)	$20 co-pay per test	20% coinsurance	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	$100 co-pay per test	20% coinsurance	Not Covered	Preauthorization Required

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Participating Provider	In-Network Provider	Out of Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.healthalliance.org/media/Resources/Health-Alliance-Comprehensive-Formulary-Private-2018.pdf	Preferred Generic and Preventive drugs	$0 co-pay / prescription	$0 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Non-Preferred Generic drugs	$10 co-pay / prescription	$10 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Preferred Brand drugs	$40 co-pay / prescription	$40 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Non-Preferred Brand drugs	$80 co-pay / prescription	$80 co-pay / prescription	Not Covered	Covers up to a 30-day supply; 90-day supply available for 2.75 co-pays.
	Preferred Specialty drugs	50% coinsurance	50% coinsurance	Not Covered	Preauthorization is required.
	Non-Preferred Specialty drugs	50% coinsurance	50% coinsurance	Not Covered	Preauthorization is required.
	Medical Drugs	50% coinsurance	50% coinsurance	Not Covered	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Not Covered	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Not Covered	--none--
If you need immediate medical attention	Emergency room care	$350 co-pay/visit	$350 co-pay/visit	$350 co-pay/visit	Participating Benefit Applies
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Participating Benefit Applies
	Urgent care	$35 co-pay/visit	$60 co-pay/visit	$60 co-pay/visit	Participating Benefit Applies
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Not Covered	--none--
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Not Covered	--none--

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Participating Provider	In-Network Provider	Out of Network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 co-pay/visit	$25 co-pay/visit	Not Covered	--none--
	Inpatient services	10% coinsurance	20% coinsurance	Not Covered	--none—
If you are pregnant	Office visits	10% coinsurance for routine prenatal care	20% coinsurance for routine prenatal care	Not Covered	--none--
	Childbirth/delivery professional services	10% coinsurance for routine prenatal care	20% coinsurance for routine prenatal care	Not Covered	--none--
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Not Covered	--none--
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	10% coinsurance	20% coinsurance	Not Covered	60 visits per condition per plan year maximum.
	Habilitation services	10% coinsurance	20% coinsurance	Not Covered	60 visits per condition per plan year maximum.
	Skilled nursing care	10% coinsurance	20% coinsurance	Not Covered	--none--
	Durable medical equipment	10% coinsurance	20% coinsurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	Hospice services	10% coinsurance	20% coinsurance	Not Covered	--none--
If your child needs dental or eye care	Children's eye exam	$0 co-pay / exam	$0 co-pay / exam	Not Covered	One routine eye exam per plan year.
	Children's glasses	$0 co-pay / item	$0 co-pay / item	Not Covered	One item per plan year.
	Children's dental check-up	Refer to Delta Dental Materials	Refer to Delta Dental Materials	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)
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Weight Loss Programs

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic Care • Hearing Aids(Pediatric)	• Infertility Services • Private-Duty Nursing	• Routine eye Care(Adult) • 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, the 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 group health coverage subject to ERISA, contact Health Alliance at 1-800-851-3379.
Also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and State of Illinois Department of Insurance at 1-877-527-9431 or consumer_complaints@ins.state.il.us.

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 $2,000
- Specialist $35 co-pay/visit
- Hospital (facility) 10% coinsurance
- Other 10% 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	$2,000
Copayments	$300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,360

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $750
- Specialist $30 co-pay/visit
- Hospital (facility) 10% coinsurance
- Other 10% 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	$1,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,460

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $750
- Specialist $30 co-pay/visit
- Hospital (facility) 10% coinsurance
- Other 10% 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	$1,200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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

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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. Llame 1-800-851-3379 (TTY: 711).

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）。

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تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء 1-800-851-3379 (TTY: 711).

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

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

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