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, visit www.HealthAlliance.org. 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 deductible?	$4,200 Individual/ $8,400 Family In-Network Does not apply to Pediatric dental exam. $8,400 Individual/ $16,800 Family Out of Network Does not apply to Pediatric dental exam.	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. Preventive/Wellness Care, Primary Care Visits, Prescription Drugs, Mental Health/ Substance Use Visits, Specialty Visits, Pediatric Vison Care, Urgent Care, Pediatric Dental Exam	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?	Yes. $150 per member for Pediatric Dental There are no other specific **deductibles**	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 out-of-pocket limit for this plan?	$8,750 Individual/ $17,500 Family In-Network $20,900 Individual/ $41,800 Family Out of Network	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, balance billing** charges, 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**

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.healthalliance.org/Guests/ProviderSearch/q?Criteria.DirectoryName= 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). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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	$35 copay /visit	50% coinsurance	--none--
	Specialist visit	$55 copay /visit	50% coinsurance	--none--
	Preventive care / screening / immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what you plan will pay for. Refer to Wellness Brochure.
If you have a test	Diagnostic test (x-ray, blood work)	$50 per test and Deductible then 40% coinsurance	50% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Preauthorization Required
If you need drugs to treat your illness or condition	Tier 1 Preferred Generic drugs	$0 copay /prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 3 copays.

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)	
More information about prescription drug coverage is available at https://www.healthalliance.org/pharmacy	Tier 2 Non-Preferred Generic drugs	$10 copay /prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 3 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Tier 3 Preferred Brand drugs	$40 copay /prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 3 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Tier 4 Non-Preferred Brand drugs	$80 copay /prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 3 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.healthalliance.org/pharmacy	Tier 5 Preferred Specialty drugs	$150 copay / prescription	50% coinsurance	Preauthorization is required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Tier 6 Non-Preferred Specialty drugs	$250 copay / prescription	50% coinsurance	Preauthorization is required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$600 per procedure and Deductible then 40% coinsurance	50% coinsurance	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	--none--
If you need immediate medical attention	Emergency room care	$600 copay /visit and Deductible then 40% coinsurance	$600 copay /visit and Deductible then 40% coinsurance	Participating Benefits Apply
	Emergency medical transportation	40% coinsurance	40% coinsurance	Participating Benefits Apply
	Urgent care	$55 copay /visit	$55 copay /visit	Participating Benefits Apply
If you have a hospital stay	Facility fee (e.g., hospital room)	$800 per stay and Deductible then 40% coinsurance	50% coinsurance	--none--
	Physician/surgeon fees	40% coinsurance	50% coinsurance	--none--

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 mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay /visit	50% coinsurance	--none--
	Inpatient services	$800 per stay and Deductible then 40% coinsurance	50% coinsurance	--none--
If you are pregnant	Office visits	40% coinsurance for routine prenatal care	50% coinsurance	--none--
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	--none--
	Childbirth/delivery facility services	$800 per stay and Deductible then 40% coinsurance	50% coinsurance	--none--
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	--none--
	Rehabilitation services	40% coinsurance	50% coinsurance	Preauthorization is required. 60 visits per condition per plan year maximum.
	Habilitation services	40% coinsurance	50% coinsurance	60 visits per condition per plan year maximum.
	Skilled nursing care	40% coinsurance	50% coinsurance	Preauthorization is required.
	Durable medical equipment	40% coinsurance	50% coinsurance	Preauthorization may be required for certain medical equipment. Contact Customer Solutions for detailed information.
	Hospice service	40% coinsurance	50% coinsurance	--none--
If your child needs dental or eye care	Children's eye exam	$0 per exam	50% coinsurance	One routine eye exam per plan year
	Children's glasses	$0 per item	$0 per item	One item per plan year
	Children's dental check-up	$0	Not Covered	One exam every 6 months

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.)

- Cosmetic Surgery (limited)
- Dental Care (Adult)
- Long-Term Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Elective Abortion
- Hearing Aids (Pediatric)
- Infertility Services
- Non-Emergency Care When Traveling Outside the US
- 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, the 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? 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.

About these Coverage Examples:

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 **$4,200**
- Specialist **$55 per visit**
- Hospital (facility) **$800 per stay and Deductible then 40%**
- Other **40%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,200
Copayments	$800
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,660

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

- The plan's overall deductible **$4,200**
- Specialist **$55 per visit**
- Hospital (facility) **$800 per stay and Deductible then 40%**
- Other **40%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,720

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

- The plan's overall deductible **$4,200**
- Specialist **$55 per visit**
- Hospital (facility) **$800 per stay and Deductible then 40%**
- Other **40%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,700

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

DISCRIMINATION IS AGAINST THE LAW

Health Alliance 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 does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us,
  such as:
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  - 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 Medical Plans, Customer Service, 3310 Fields South Drive, Champaign, IL 61822, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, 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, 1-800-368-1019, TTY: 1-800-537-7697. 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. 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）。

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

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).

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

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

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).

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).

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

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

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

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-851-3379 (TTY: 711).