



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 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 Individual/\$0 Family \$5,000 Individual/\$10,000 Family Out of 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. Wellness Care, Emergency Room Visits, and Emergency Transportation.	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?	\$3,000 Individual/ \$6,000 Family For In-network Providers \$10,000 Individual/ \$20,000 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 <u>out-of-pocket limit</u>?	Deductibles, Durable Medical Equipment and Prosthetics, Eye Exams, Healthcare this plan does not cover, Maximum Allowable Charges, Office Visits, NonWellness contraceptive devices/injectibles, Preauthorization Penalties, Preexisting limitations (if applicable), Premiums, Prescription Drugs, Spinal Manipulations	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.
Will you pay less if you use a <u>network provider</u>?	Yes. See: https://www.healthalliance.org/Guests/ProviderSearch?DirectoryName=ALL#Criteria.DirectoryName=ALL or call 1-800-851-3379 for a list of <u>Participating (In-network) providers</u>.	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>).
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes, this plan may require referrals to in-network specialists.	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.

 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	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	--none--
	<u>Specialist</u> visit	\$65 <u>copay</u> /visit	50% <u>coinsurance</u>	--none--
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	50% <u>coinsurance</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	--none--
	Imaging (CT/PET scans, MRIs)	\$1,000 then 30% per service	50% <u>coinsurance</u>	<u>Preauthorization</u> Required
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://healthalliance.org/documents/formulary/666/2021	Preferred Formulary Generic drugs	\$7 <u>copay</u> / prescription	50% <u>coinsurance</u>	Covers up to a 30-day supply; 90 day supply available for 2.75 co-pays.
	Preferred Formulary brand drugs	\$35 <u>copay</u> / prescription	50% <u>coinsurance</u>	Covers up to a 30-day supply; 90 day supply available for 2.75 co-pays.
	Non-preferred Formulary brand drugs	\$70 <u>copay</u> / prescription	50% <u>coinsurance</u>	Covers up to a 30-day supply; 90 day supply available for 2.75 co-pays.
	Preferred Formulary (Tier 4) <u>Specialty drugs</u>	\$140 <u>copay</u> / prescription	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Non-Preferred Formulary (Tier 5) <u>Specialty drugs</u>	\$210 <u>copay</u> / prescription	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Non-Formulary (Tier 6) <u>Specialty drugs</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Preventive Drugs (Tier 7)	No Charge	50% <u>coinsurance</u>	--none--
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$2,000 then 30% per service	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	--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 need immediate medical attention	Emergency room care	\$250 <u>copay</u> / visit	\$250 <u>copay</u> / visit	Participating Benefit Applies
	Emergency medical transportation	\$150 <u>copay</u>	\$150 <u>copay</u>	Participating Benefit Applies
	Urgent care	\$80 <u>copay</u> / visit	50% <u>coinsurance</u>	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,000 then 30% per stay	50% <u>coinsurance</u>	--none--
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	--none--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	--none--
	Inpatient services	\$2,000 then 30% per stay	50% <u>coinsurance</u>	--none--
If you are pregnant	Office visits	30% <u>coinsurance</u> for routine prenatal care	50% <u>coinsurance</u>	--none--
	Childbirth/delivery professional services	\$2,000 then 30% per stay	50% <u>coinsurance</u>	--none--
	Childbirth/delivery facility services	\$2,000 then 30% per stay	50% <u>coinsurance</u>	--none--
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. 60 visits per condition per plan year maximum.
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits per condition per plan year maximum.
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Durable medical equipment	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required for certain medical equipment. Contact Customer Service for detailed information.
	Hospice services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	--none--
If your child needs dental or eye care	Children's eye exam	\$40 <u>copay</u> / exam	Not Covered	Once every 12 months
	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 | • Dental Care (Adult) | • Long-Term Care |
| • Cosmetic Surgery(limited) | • Infertility Services | • Weight Loss Programs |

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

- | | | |
|---------------------------|--|---------------------------|
| • Bariatric Surgery | • Non-Emergency Care When Traveling Outside the U.S. | • Private-Duty Nursing |
| • Chiropractic Care | | • Routine eye Care(Adult) |
| • Hearing Aids(Pediatric) | | • 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 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.

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 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](#) \$65 [co-pay/visit](#)
- Hospital (facility) \$2,000 then 30% [coinsurance](#)
- Other 30% [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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,200
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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](#) \$65 [co-pay/visit](#)
- Hospital (facility) \$2,000 then 30% [coinsurance](#)
- Other 30% [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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$400
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](#) \$0
- [Specialist](#) \$65 [co-pay/visit](#)
- Hospital (facility) \$2,000 then 30% [coinsurance](#)
- Other 30% [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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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 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 ، 1-800-851-3379 (TTY: 711) مجاناً ، تتوفر لك . ستدعاء
Wenn Sie Deutsch sprechen, Sprachassistentendienste 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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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).