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, contact HealthAlliance.org or call 1-800-322-7451. 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.dol.gov/agencies/ebsa or call 1-800-322-7451 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Per calendar year: January - December** **Preferred: $1,000** single / **$3,000** family **Non-Preferred**: **$2,000** single / **$6,000** family	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. The following services are not subject to deductible: emergency room care, urgent care, emergency medical transportation, spinal manipulations and Preferred: office visits, preventive care and prescription drugs.	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?	**Per calendar year: January - December** **Preferred**: **$4,500** single / **$12,000** family **Non-Preferred**: **$14,000** single / **$32,000** family	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-billed charges, health care this plan doesn't cover, preauthorization penalties, charges over the maximum allowable charge.	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 HealthAlliance.org or call 1-800-322-7451 for a list of 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?	No.	You can see the specialist you choose without a referral.

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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$25 copayment per visit	50% coinsurance, after deductible	None
	Specialist visit	- $50 copayment per visit - Spinal Manipulations: 50% coinsurance	- 50% coinsurance, after deductible - Spinal Manipulations: 50% coinsurance	Spinal Manipulations limited to $500 per calendar year.
	Preventive care/screening/ immunization	No charge	50% coinsurance, after deductible	Age, gender, & frequency limits may apply. Please see the preventive care section(s) of your plan document. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization on select tests may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization on select tests may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at HealthAlliance.org .	Generic drugs	Category 1: $7 copayment per prescription (retail) and $19.25 copayment per prescription (mail-order)	50% coinsurance, after deductible	Covers 30 day supply for retail and 90 day supply for mail order. Preauthorization on select drugs may be required.
	Preferred brand drugs	Category 2: $35 copayment per prescription (retail) and $96.25 copayment per prescription (mail-order)	50% coinsurance, after deductible	Covers 30 day supply for retail and 90 day supply for mail order. Preauthorization on select drugs may be required.
	Non-preferred brand drugs	Category 3: $70 copayment per prescription (retail) and $192.50 copayment per prescription (mail-order)	50% coinsurance, after deductible	Covers 30 day supply for retail and 90 day supply for mail order. Preauthorization on select drugs may be required.
	Specialty drugs	Category 4: $140 copayment per prescription Category 5: $210 copayment per prescription Category 6: 50% coinsurance per prescription	50% coinsurance, after deductible	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization on select surgeries may be required.
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization on select surgeries may be required.
If you need immediate medical attention	Emergency room care	$200 copayment per visit	$200 copayment per visit	None
	Emergency medical transportation	$100 copayment per transport	$100 copayment per transport	None
	Urgent care	$50 copayment per visit	$50 copayment per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment per visit	50% coinsurance, after deductible	None
	Inpatient services	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance, after deductible	50% coinsurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.
	Rehabilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	- Inpatient Rehabilitation: Preauthorization is required. Limited to 120 days per calendar year combined with Skilled Nursing Care. - Outpatient Rehabilitation: Therapy limited to 60 visits per condition per calendar year. - Cardiac Rehabilitation: limited to 36 sessions per calendar year.
	Habilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	
	Skilled nursing care	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required. Limited to120 days per calendar year combined with Inpatient Rehabilitation.
	Durable medical equipment	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization on select DME may be required.
	Hospice services	20% coinsurance, after deductible	50% coinsurance, after deductible	None
If your child needs dental or eye care	Children's eye exam	$40 copayment per visit	50% coinsurance, after deductible	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 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
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Chiropractic care
- Infertility treatment
- 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: the Plan at 1-217-834-3309 or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Health Alliance at 1-800-322-7451. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor, Employee Benefits Security Administration at 1-866-487-2365 or visit www.dol.gov/ebsa/healthreform or visit 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 1-800-322-7451.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-322-7451.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-322-7451.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-322-7451.

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	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$30
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,390**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) copayment	**$200**
Other coinsurance	**20%**

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	$600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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

IMPORTANT

Section 1557 of PPACA, a federal law, requires that you be provided this notice.

The notice does not change the terms of your coverage and/or benefits under your employer-sponsored health plan.

Please review the information and keep it with your plan materials.

NO FURTHER ACTION IS REQUIRED ON YOUR PART.

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:
  - 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: 217-902-9705, 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/smartscreen/main.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 https://www.hhs.gov/ocr/filing-with-ocr/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

ةيبنت :ةيبرعلا ةغللا ثدحتتت تنك اذإ ، ةيوغللا ةدعاسملا تامدخ ، ناجم ، كلذ رفوتت . ءاعدتسا 1-800-851-3379 (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

ધ્યા: તમે વયત તો □ુજરયતી, ભયષય સહય્ સેવયઓ, મફત, તમયરય મયટ□ ઉપલબ્ 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

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