



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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-322-7451 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: Not applicable Non-Preferred Provider: \$5,000 single / \$10,000 family Per calendar year: January - December	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. The following services are not subject to <u>deductible</u> : <u>emergency room care</u> , <u>emergency medical transportation</u> , acupuncture and spinal manipulations.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Preferred Provider: \$4,000 single / \$8,000 family Non-Preferred Provider: \$10,000 single / \$20,000 family Per calendar year: January - December	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, <u>preauthorization</u> penalties, charges over the maximum allowable charge	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 network provider?	Yes. See HealthAlliance.org or call 1-800-322-7451 for a list of <u>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</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes. A <u>referral</u> may be required to see a <u>specialist</u> when utilizing <u>participating providers</u> . No <u>referral</u> is needed for <u>non-participating providers</u> .	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 <u>specialist</u> .



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 <u>copayment</u> per visit	50% <u>coinsurance</u> , after <u>deductible</u>	None
	<u>Specialist</u> visit	\$50 <u>copayment</u> per visit	50% <u>coinsurance</u> , after <u>deductible</u>	Spinal manipulations: Limited to \$500 per calendar year. Acupuncture: Limited to 15 visits per calendar year.
		Spinal manipulations: 50% <u>coinsurance</u>	Spinal manipulations: 50% <u>coinsurance</u>	
	Acupuncture: \$25 <u>copayment</u> per visit <u>Preferred provider</u> benefits apply			
<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u> , after <u>deductible</u>	Age, gender, & frequency limits may apply. Please see the <u>preventive care</u> section(s) of your <u>plan</u> document. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> on select tests may be required.
	Imaging (CT/PET scans, MRIs)	\$1,000 <u>copayment</u> per procedure then 20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> on select tests may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 1-833-956-1787.	Tier 1 (Generic drugs)	- Retail: \$10 <u>copayment</u> per prescription - Mail order: \$27.50 <u>copayment</u> per prescription	50% <u>coinsurance</u> , after <u>deductible</u>	- Retail: Limited to a maximum 30-day supply - Mail order: Limited to a maximum 90-day supply - <u>Preauthorization</u> on select drugs may be required.
	Tier 2 (Preferred brand drugs)	- Retail: \$40 <u>copayment</u> per prescription - Mail order: \$110 <u>copayment</u> per prescription	50% <u>coinsurance</u> , after <u>deductible</u>	
	Tier 3 (Non-preferred brand drugs)	- Retail: \$80 <u>copayment</u> per prescription - Mail order: \$220 <u>copayment</u> per prescription	50% <u>coinsurance</u> , after <u>deductible</u>	
	Tier 4, 5 & 6 (Specialty drugs)	50% <u>coinsurance</u> per prescription	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required.



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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$2,000 <u>copayment</u> per procedure then 20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> on select surgeries may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> on select surgeries may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copayment</u> per visit	\$200 <u>copayment</u> per visit	None
	<u>Emergency medical transportation</u>	\$100 <u>copayment</u> per visit	\$100 <u>copayment</u> per visit	None
	<u>Urgent care</u>	\$50 <u>copayment</u> per visit	50% <u>coinsurance</u> , after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,000 <u>copayment</u> per admission then 20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> per visit	50% <u>coinsurance</u> , after <u>deductible</u>	None
	Inpatient services	\$2,000 <u>copayment</u> per admission then 20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	Cost sharing does not apply for <u>preferred preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> 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	\$2,000 <u>copayment</u> per admission then 20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	



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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	- Inpatient <u>rehabilitation</u> : <u>Preauthorization</u> is required. Limited to 120 days per calendar year combined with <u>skilled nursing care</u> . - Outpatient <u>rehabilitation</u> : Therapy limited to 60 visits per calendar year (occupational, speech & physical therapies combined). - Cardiac <u>rehabilitation</u> : limited to 36 sessions, within six months of event, per calendar year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. Limited to 120 days per calendar year combined with inpatient <u>rehabilitation</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> on select <u>durable medical equipment</u> may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> , after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	\$40 <u>copayment</u> per visit	Not covered	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.)

- 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.)

- Acupuncture
- 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 on how 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

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 1-800-322-7451.

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, kwijigo 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	\$0
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$2,000
■ 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,000
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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 copayment	\$50
■ Hospital (facility) copayment	\$2,000
■ 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-851-3379; telephone for members in Washington: 1-877-750-3515 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/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. IA, IL, IN, OH: Llame 1-800-851-3379, WA Llame: 1-877-750-3515 (TTY: 711).

注意: 如果你講中文, 語言協助服務, 免費的, 都可以給你。IA, IL, IN, OH: 呼叫 1-800-851-3379, WA: 呼叫 1-877-750-3515 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-851-3379, WA: Zadzwoń 1-877-750-3515 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-851-3379, WA: Gọi 1-877-750-3515 (TTY: 711).

주의: 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 IA, IL, IN, OH: 전화 WA: 1-877-750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-851-3379, WA: Вызов 1-877-750-3515 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-851-3379, WA: Tumawag 1-877-750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-851-3379، ولاية واشنطن: اتصل بالرقم: 1-877-750-3515 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistentendienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-851-3379, WA: Anruf 1-877-750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-851-3379, WA: Appelez 1-877-750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કોલ 1-800-851-3379, WA: કોલ 1-877-750-3515 (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 IA, IL, IN, OH: コール 1-877-750-3515 WA: コール (TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-851-3379, WA: Bel 1-877-750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-851-3379, WA: Виклик 1-877-750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-851-3379, WA: Chiamare 1-877-750-3515 (TTY: 711).