




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 <u>deductible</u> ?	<p>\$100 Individual/\$200 Family In-Network Participating Provider</p> <p>\$300 Individual/\$600 Family In-Network</p>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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 <u>deductible</u> ?	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 <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<p>\$2,000 Individual/ \$4,000 Family For In-network Participating Providers</p> <p>\$3,000 Individual/ \$6,000 Family For In-network Providers</p>	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 <u>out-of-pocket limit</u> ?	Premiums, healthcare this plan does not cover, Out of Network Precert Penalties.	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: <a href="https://www.healthalliance.org/Guests/ProviderSearch/q?Criteria.DirectoryName=S01">https://www.healthalliance.org/Guests/ProviderSearch/q?Criteria.DirectoryName=S01</a> 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		Out of Network Provider	Limitations, Exceptions, & Other Important Information
		In-Network Participating Provider	In-Network Provider		
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 co-pay/visit	\$20 co-pay/visit	Not Covered	--none--
	<u>Specialist</u> visit	\$30 co-pay/visit	\$30 co-pay/visit	Not Covered	--none--
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	Refer to Wellness Brochure
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 co-pay per test	15% coinsurance	Not Covered	--none--
	Imaging (CT/PET scans, MRIs)	\$100 co-pay per test	15% coinsurance	Not Covered	Preauthorization Required

\* For more information about limitations and exceptions, see the plan or policy document at [www.HealthAlliance.org](http://www.HealthAlliance.org).

Common Medical Event	Services You May Need	What You Will Pay		Out of Network Provider	Limitations, Exceptions, & Other Important Information
		In-Network Participating Provider	In-Network Provider		
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://www.healthalliance.org/media/Resources/Health-Alliance-Comprehensive-Formulary-Private-2018.pdf">prescription drug coverage</a> is available at <a href="https://www.healthalliance.org/media/Resources/Health-Alliance-Comprehensive-Formulary-Private-2018.pdf">https://www.healthalliance.org/media/Resources/Health-Alliance-Comprehensive-Formulary-Private-2018.pdf</a>	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	\$35 co-pay / prescription	\$35 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	\$70 co-pay / prescription	\$70 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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	15% coinsurance	Not Covered	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	5% coinsurance	15% coinsurance	Not Covered	--none--
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 co-pay/visit	\$300 co-pay/visit	\$300 co-pay/visit	Participating Benefit Applies
	<a href="#">Emergency medical transportation</a>	5% coinsurance	5% coinsurance	5% coinsurance	Participating Benefit Applies
	<a href="#">Urgent care</a>	\$30 co-pay/visit	\$50 co-pay/visit	\$50 co-pay/visit	Participating Benefit Applies
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	5% coinsurance	15% coinsurance	Not Covered	--none--
	Physician/surgeon fees	5% coinsurance	15% coinsurance	Not Covered	--none--

\* For more information about limitations and exceptions, see the plan or policy document at [www.HealthAlliance.org](http://www.HealthAlliance.org).

Common Medical Event	Services You May Need	What You Will Pay		Out of Network Provider	Limitations, Exceptions, & Other Important Information
		In-Network Participating Provider	In-Network Provider		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 co-pay/visit	\$20 co-pay/visit	Not Covered	--none--
	Inpatient services	5% coinsurance	15% coinsurance	Not Covered	--none--
If you are pregnant	Office visits	5% coinsurance for routine prenatal care	15% coinsurance for routine prenatal care	Not Covered	--none--
	Childbirth/delivery professional services	5% coinsurance for routine prenatal care	15% coinsurance for routine prenatal care	Not Covered	--none--
	Childbirth/delivery facility services	5% coinsurance	15% coinsurance	Not Covered	--none--
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	5% coinsurance	15% coinsurance	Not Covered	Preauthorization is required.
	<a href="#">Rehabilitation services</a>	5% coinsurance	15% coinsurance	Not Covered	60 visits per condition per plan year maximum.
	<a href="#">Habilitation services</a>	5% coinsurance	15% coinsurance	Not Covered	60 visits per condition per plan year maximum.
	<a href="#">Skilled nursing care</a>	5% coinsurance	15% coinsurance	Not Covered	--none--
	<a href="#">Durable medical equipment</a>	5% coinsurance	15% coinsurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	<a href="#">Hospice services</a>	5% coinsurance	15% 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               | • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. |
| • Cosmetic Surgery(limited) | • 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.)**

- |                           |                        |                           |
|---------------------------|------------------------|---------------------------|
| • Bariatric Surgery       | • Infertility Services | • Routine eye Care(Adult) |
| • Chiropractic Care       | • Private-Duty Nursing | • Routine foot care       |
| • Hearing Aids(Pediatric) |                        |                           |

**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](http://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](http://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](http://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](http://www.dol.gov/ebsa/healthreform) and State of Illinois Department of Insurance at 1-877-527-9431 or [consumer\\_complaints@ins.state.il.us](mailto: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](mailto: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](http://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, 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](#) \$100
- [Specialist](#) \$30 [co-pay/visit](#)
- Hospital (facility) 5% [coinsurance](#)
- Other 5% [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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist](#) \$30 [co-pay/visit](#)
- Hospital (facility) 5% [coinsurance](#)
- Other 5% [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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$510

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist](#) \$30 [co-pay/visit](#)
- Hospital (facility) 5% [coinsurance](#)
- Other 5% [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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$400
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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:
  - 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](mailto: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: 당신이 한국어, 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 . استدعاء

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).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કોલ 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).