Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
POS 2500B 19 Rx231

Coverage Period: 10/01/2020 - 09/30/2021
Coverage for: Individual + Family | **Plan Type:** POS

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 www.healthalliance.org or call 1-800-851-3379 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 Individual/ $5,000 Family In-Network $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. Preventive/Wellness Care, Primary Care Visits, Prescription Drugs, Mental Health/ Substance Use Visits, Specialty Visits, Urgent Care, Emergency Room Visits, Emergency Ambulance 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?	$5,000 Individual/ $10,000 Family In-Network $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 out-of-pocket limit?	Premiums, 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
Will you pay less if you use a network provider?	Yes. See https://www.healthalliance.org/Guests/ProviderSearch 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.

Important Questions	Answers	Why This Matters:
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	$25 co-pay/visit	40% coinsurance	--none--
	Specialist visit	$40 co-pay/visit	40% coinsurance	--none--
	Preventive care/screening/immunization	No Charge	40% coinsurance	Refer to Wellness Brochure
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization Required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.healthalliance.org/pharmacy	Preferred Generic drugs	$0 copay/prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.75 co-pays.
	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 2.75 co-pays.
	Preferred Brand drugs	$40 copay/prescription	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) available for 2.75 co-pays.
	Non-Preferred Brand drugs	$80 copay/prescription	50% coinsurance	Preauthorization is required.
	Preferred Specialty drugs	30% coinsurance	50% coinsurance	Preauthorization is required.
	Non-Preferred Specialty drugs	50% coinsurance	50% coinsurance	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures. Contact customer Service for detailed information.
	Physician/surgeon fees	20% coinsurance	40% 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 need immediate medical attention	Emergency room care	$250 co-pay/visit	$250 co-pay/visit	Participating Benefits Apply
	Emergency medical transportation	$100 per transport	$100 per transport	Participating Benefits Apply
	Urgent care	$50 co-pay/visit	40% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-pay/visit	40% coinsurance	--none--
	Inpatient services	20% coinsurance	40% coinsurance	--none--
If you are pregnant	Office visits	20% coinsurance for routine prenatal care	40% coinsurance	--none--
	Childbirth/delivery professional services	20% coinsurance for routine prenatal care	40% coinsurance	--none--
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	--none--
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits per condition per plan year maximum.
	Habilitation services	20% coinsurance	40% coinsurance	60 visits per condition per plan year maximum.
	Skilled nursing care	20% coinsurance	40% coinsurance	--none--
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required for certain medical equipment. Contact Customer Solutions for detailed information.
	Hospice service	20% coinsurance	40% coinsurance	--none--
If your child needs dental or eye care	Children's eye exam	$40 per exam	Not Covered	--none--
	Children's glasses	Not Covered	Not Covered	--none--
	Children's dental check-up	Not Covered	Not Covered	--none--

* For more information about limitations and exceptions, see the plan or policy document at www.HealthAlliance.org.