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 https://www.healthalliance.org/documents/1492 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, balance billing charges, 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 copay /visit	40% coinsurance	--none--
	Specialist visit	$40 copay /visit	40% coinsurance	--none--
	Preventive care / screening / immunization	No Charge	40% coinsurance	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	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://healthalliance.org/documents/formulary/222/2023	Tier 1 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 copays.
	Tier 2 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 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://healthalliance.org/documents/formulary/222/2023	Tier 3 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 copays. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Tier 4 Non-Preferred Brand drugs	$80 copay /prescription	50% coinsurance	Preauthorization is required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Tier 5 Preferred Specialty drugs	30% coinsurance	50% coinsurance	Preauthorization is required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://healthalliance.org/documents/formulary/222/2023	Tier 6 Non-Preferred Specialty drugs	50% coinsurance	50% coinsurance	Preauthorization is required. If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
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--
If you need immediate medical attention	Emergency room care	$250 copay /visit	$250 copay /visit	Participating Benefits Apply
	Emergency medical transportation	$100 copay /transport	$100 copay /transport	Participating Benefits Apply
	Urgent care	$50 copay /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 copay /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	40% coinsurance	--none--
	Childbirth/delivery facility services	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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	--none--
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required. 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	Preauthorization is required.
	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--

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 (limited)
- Dental Care (Adult)
- Hearing Aids (Adult)
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Elective Abortion
- Infertility Services
- Non-Emergency Care When Traveling Outside the US
- Private-Duty Nursing
- 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: 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**. For non-federal governmental group health plans, the 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 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.

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 Coverage Meet the Minimum Value Standard? 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, kwiijigo holne' 1-800-851-3379.

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	**$2,500**
Specialist	**$40 per visit**
Hospital (facility)	**20%**
Other	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,560

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

The plan's overall deductible	**$2,500**
Specialist	**$40 per visit**
Hospital (facility)	**20%**
Other	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,820

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

The plan's overall deductible	**$2,500**
Specialist	**$40 per visit**
Hospital (facility)	**20%**
Other	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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, 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: (800) 851-3379; members in Washington call: (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, (800) 368-1019 (TTY: (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 (800) 851-3379, WA Llame: (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 (800) 851-3379, WA: 呼叫 (877) 750-3515（TTY: 711）。

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

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

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

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

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

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

LET OP: Services Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711).

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