




This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthalliance.org. or by calling 1-800-851-3379.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,000 person / \$4,000 family Doesn't apply to Office Visit, Urgent Care, Spinal Manipulations, Prescription Drugs, Emergency Room Visits, Ambulance, Vision Exam and Preventive Services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$2,000 individual / \$4,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Health care this plan does not cover, Maximum Allowable Charges, Preauthorization Penalties, Premiums.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.healthalliance.org or call 1-800-851-3379 for a list of participating providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes. A referral may be required to see a specialist. You must utilize participating providers to guarantee coverage, except in an emergency situation.	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-851-3379 or visit us at www.healthalliance.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.healthalliance.org or call 1-800-851-3379 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
 - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
 - This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay per visit. Additional services obtained while in the office may require an additional Deductible, Copay or Coinsurance amount.	Not Covered	-----None-----
	Specialist visit	\$50 copay per visit. Additional services obtained while in the office may require an additional Deductible, Copay or Coinsurance amount.	Not Covered	-----None-----
	Other practitioner office visit	50% coinsurance spinal manipulations	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	One preventive visit and/or well women visit per plan year.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	Certain tests may require preauthorization. Please contact Customer Service for details.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	Certain tests may require preauthorization. Please contact Customer Service for details.

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Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthalliance.org .	Generic drugs	\$7 copay	Not Covered	Covers a 30-day supply. 90-day option available for 2.75 copays. Some drugs may require preauthorization.
	Preferred brand drugs	\$25 copay	Not Covered	Covers a 30-day supply. 90-day option available for 2.75 copays. Some drugs may require preauthorization.
	Non-preferred brand drugs	\$50 copay	Not Covered	Covers a 30-day supply. 90-day option available for 2.75 copay. Some drugs may require preauthorization.
	Preferred specialty drugs	\$100 copay	Not Covered	Preauthorization Required
	Non-preferred specialty drugs	\$150 copay	Not Covered	Preauthorization Required
	Non-formulary specialty drugs	50% coinsurance	Not Covered	Preauthorization Required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	Some procedures require preauthorization. Please contact Customer Service for more information.
	Physician/surgeon fees	0% coinsurance	Not Covered	Some procedures require preauthorization. Please contact Customer Service for more information.
If you need immediate medical attention	Emergency room services	\$200 copay	\$200 copay	-----None-----
	Emergency medical transportation	\$100 copay	\$100 copay	-----None-----
	Urgent care	\$50 copay	\$50 copay	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	-----None-----
	Physician/surgeon fee	0% coinsurance	Not Covered	-----None-----

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Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental Behavioral health outpatient services	\$25 copay/visit	Not Covered	-----None-----
	Mental Behavioral health inpatient services	0% coinsurance	Not Covered	-----None-----
	Substance use disorder outpatient services	\$25 copay/visit	Not Covered	-----None-----
	Substance use disorder inpatient services	0% coinsurance	Not Covered	-----None-----
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	-----None-----
	Delivery and all inpatient services	0% coinsurance	Not Covered	-----None-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	0% coinsurance	Not Covered	60 visits per condition per plan year
	Habilitation services	0% coinsurance	Not Covered	See rehabilitation visit maximum.
	Skilled nursing care	0% coinsurance	Not Covered	-----None-----
	Durable medical equipment	0% coinsurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	Hospice service	0% coinsurance	Not Covered	-----None-----
If your child needs dental or eye care	Eye exam	\$40 copay / exam	Not Covered	-----None-----
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|--------------------------------------|
| • Acupuncture | • Hearing Aids | • Private-Duty Nursing |
| • Cosmetic Surgery | • Long-Term Care | • Temporomandibular Joint (TMJ) Care |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. | • Weight Loss Programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|----------------------------|---------------------|
| • Bariatric Surgery | • Infertility Treatment | • Routine Foot Care |
| • Chiropractic Care | • Routine Eye Care (Adult) | |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-851-3379. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Health Alliance at 1-800-851-3379. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform or the Illinois Department of Insurance at 1-877-850-4740 or www.ins.state.il.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.*-----

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays **\$2330**
- Patient pays **\$5210**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5000
Copays	\$10
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$5210

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays **\$4020**
- Patient pays **\$1380**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$700
Copays	\$600
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1380

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



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, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, 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>.

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 : 당신이 한국어, 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

1-800-851-3379 (TTY: 711) تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . استدعاء

German

Wenn Sie Deutsch sprechen, Sprachassistentendienste 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

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