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 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**: **$1,000** Single / **$3,000** Family **Non-Preferred Provider**: **$2,000** Single / **$6,000** Family	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. The following services are not subject to deductible: Prescription drugs and the following preferred provider services: office visits (includes outpatient mental health and substance use), preventive care, well-child care, annual physicals and routine eye exams.	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?	**Preferred Provider**: **$4,000** Single / **$12,000** Family **Non-Preferred Provider**: **$25,000** Single / **$75,000** Family	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?	Charges over the Maximum Allowable Charge, premiums, balance-billed charges, and health care this plan doesn't cover.	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 HealthAlliance.org or call 1-800-322-7451 for a list of network providers. If you reside within the following mile radiuses you must be treated by Carle providers to receive the preferred provider benefit. – 35 miles of 61801 (Urbana), 61761 (Normal), 61530 (Eureka), 62450 (Olney), 60942 (Hoopeston), 28374 (Pinehurst), 61614 (Peoria), 61636 (Peoria) or 61554 (Pekin).	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.
Do you need a referral to see a specialist?	No.	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
		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	$20 copayment per visit, deductible does not apply	50% coinsurance, after deductible	In order to receive the preferred provider benefits, preauthorization is required for non-Carle providers if you reside within the following radiuses: - 35 miles of 61801 (Urbana), 61761 (Normal), 61530 (Eureka), 62450 (Olney), 60942 (Hoopeston), 28374 (Pinehurst), 61614 (Peoria), 61636 (Peoria) or 61554 (Pekin).
		Virtual visit: Visits 1-3: No charge Visits 4+: $20 copayment per visit, deductible does not apply	Not covered	None
	Specialist visit	$40 copayment per visit, deductible does not apply	50% coinsurance, after deductible	- Infertility services: Limited to $25,000 per lifetime. - Chiropractic care: Limited to $750 per plan year. In order to receive the preferred provider benefits, preauthorization is required for non-Carle providers if you reside within the following radiuses: - 35 miles of 61801 (Urbana), 61761 (Normal), 61530 (Eureka), 62450 (Olney), 60942 (Hoopeston), 28374 (Pinehurst), 61614 (Peoria), 61636 (Peoria) or 61554 (Pekin).
		Infertility services: 50% coinsurance, after deductible	Infertility services: 50% coinsurance, after deductible	
		Chiropractic care: 20% coinsurance, after deductible Preferred provider benefit level applies		
	Preventive care/ screening/ immunization	No charge	50% coinsurance, after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	- Outpatient laboratory services: $50 copayment per visit, deductible does not apply - Outpatient radiology services: $100 copayment per visit, deductible does not apply	50% coinsurance, after deductible	None
	Imaging (CT/PET scans, MRIs)	$250 copayment per visit, deductible does not apply	50% coinsurance, after deductible	Preauthorization is required.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at HealthAlliance.org	Tier 1 (Preferred generic)	- Retail: No charge - Mail order & Retail 90: No charge	Not covered	- Includes retail infertility drugs. - Deductible does not apply. - Mandatory generic substitution for retail and mail order. - Retail: Limited to a 30-day supply - Mail order & Retail 90: Limited to a 90-day supply
	Tier 2 (Non-preferred generic)	- Retail: $10 copayment per prescription - Mail order & Retail 90: $27.50 copayment per prescription	Not covered	
	Tier 3 (Preferred brand)	- Retail: $40 copayment per prescription - Mail order & Retail 90: $110.00 copayment per prescription	Not covered	
	Tier 4 (Non-preferred brand)	- Retail: $60 copayment per prescription - Mail order & Retail 90: $165.00 copayment per prescription	Not covered	- Deductible does not apply - Includes specialty infertility drugs. - Preauthorization is required.
	Tier 5 (Preferred specialty)	30% coinsurance	Not covered	
	Tier 6 (Non-preferred specialty)	30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	50% coinsurance, after deductible	None
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	None
If you need immediate medical attention	Emergency room care	- Visits 1-2: $200 copayment per visit per covered person, deductible, then 20% coinsurance - Visits 3+: $500 copayment per visit per covered person, deductible, then 20% coinsurance	- Visits 1-2: $200 copayment per visit per covered person, preferred provider deductible, then 20% coinsurance - Visits 3+: $500 copayment per visit per covered person, preferred provider deductible, then 20% coinsurance	None
	Emergency medical transportation	$200 copayment per transport, deductible, then 20% coinsurance	$200 copayment per transport, preferred provider deductible, then 20% coinsurance	Preauthorization is required for non-emergent ambulance.
	Urgent care	20% coinsurance, after deductible	20% coinsurance, after preferred provider deductible	None

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	- $20 copayment per office visit, deductible does not apply - All other services: 20% coinsurance, after deductible	50% coinsurance, after deductible	None
	Inpatient services	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance, after deductible	50% coinsurance, after deductible	Cost sharing does not apply for preferred provider preventive care services. Depending on the type of services, a copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required.
	Childbirth/delivery professional services	20% coinsurance, after deductible	50% coinsurance, after deductible	
	Childbirth/delivery facility services	20% coinsurance, after deductible	50% coinsurance, after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	50% coinsurance, after deductible	Limited to 100 visits per plan year (preferred and non-preferred provider services combined).
	Rehabilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	- Preauthorization is required for inpatient services. - Inpatient rehabilitation and skilled nursing care: Limited to 120 days per plan year. - Outpatient rehabilitation services: Limited to 60 visits per plan year (preferred and non-preferred provider services combined) (speech, occupational and physical therapies are combined).
	Habilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	
	Skilled nursing care	20% coinsurance, after deductible	50% coinsurance, after deductible	
	Durable medical equipment	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required on select durable medical equipment.
	Hospice services	20% coinsurance, after deductible	50% coinsurance, after deductible	Preauthorization is required.

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 your child needs dental or eye care	Children's eye exam	$40 copayment per visit, deductible does not apply	50% coinsurance, after deductible	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.)

- Acupuncture
- 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.)

- Bariatric surgery (Preauthorization is required)
- Chiropractic care
- Infertility treatment (limited to $25,000 per lifetime)
- 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 1-217-383-3066 or Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) orwww.dol.gov/ebsa/healthreform. 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, kwiijigo 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	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,960**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,100
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,210**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,770**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

NOTICE

This 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

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- 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.

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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).

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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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