HMO 3500 Elite Silver CSR 94			Silver
01/01/2020		Member Responsibility	
Member Benefits		**In-Network**	**Out-of-Network**
Plan Year Deductible *Includes **Embedded Deductible.** Members on this plan who meet their individual deductibles can use their coverage before the family deductible is met.*		Single: $100 Family: $200	Single: Not Applicable Family: Not Applicable
Plan Year Out-of-Pocket Maximum Combined medical and pharmacy expenses including deductible, coinsurance amounts and copays.		Single: $2,500 Family: $5,000	Single: Not Applicable Family: Not Applicable
Walk-in Patient Services	*Annual Vision Exam*	$20 per exam	Not Covered
	Primary Care Physician Office Visit	$20 per visit	Not Covered
	Specialty Care Physician Office Visit	$40 per visit	Not Covered
	Acupuncture	$20 per visit	Not Covered
	Spinal Manipulations	$40 per visit	Not Covered
	Urgent Care	$40 per visit	In Network Benefit Applies
	Virtual Visits	$0 visits 1-3, then $20 copay	Not Covered
Emergency Services	*Emergency Department Visit*	$600 per visit and Deductible then 0%	In Network Benefit Applies
	Emergency Ambulance Transportation	Deductible, 0%	In Network Benefit Applies
Hospital Services	*Outpatient Surgery/Procedures**	$600 per procedure and Deductible then 0%	Not Covered
	*Inpatient Facility**	$800 per stay and Deductible then 0%	Not Covered
Mental Health/ Substance Abuse	*Outpatient Office Visits*	$20 per visit	Not Covered
	*Inpatient Facility**	$800 per stay and Deductible then 0%	Not Covered
Rehabilitative And Habilitative Services	*Physical Therapy*	Deductible, 0%	Not Covered
	Occupational Therapy	Deductible, 0%	Not Covered
	Durable Medical Equipment	Deductible, 0%	Not Covered
Diagnostic Services	*MRI and CT Scans*	$600 per test and Deductible then 0%	Not Covered
	Laboratory and X-rays	$5 per test and Deductible then 0%	Not Covered
Maternity *Inpatient newborn covered on mother's policy up to 96 hours*	*Routine Prenatal Care*	Deductible, 0%	Not Covered
	*Inpatient Maternity Facility**	$800 per stay and Deductible then 0%	Not Covered
	*Inpatient Newborn Facility**	$800 per stay and Deductible then 0%	Not Covered
Pediatric Services *Offered to children up to age 19*	*Pediatric Dental Exam*	$0 per exam	Not Covered
	Pediatric Vision Exam	$0 per exam	Not Covered
	Pediatric Vision Materials	$0 per item	Not Covered
Preventive & Wellness Services *Immunizations, adult and child annual physical exams, mammograms, PAP smears, cancer screenings and more. Age/frequency schedules apply.*		$0	Not Covered
Prescription Drugs Retail	*Preferred Generic – Tier 1*	$0	Not Covered
	Non-Preferred Generic – Tier 2	$10	Not Covered
	Preferred Brand – Tier 3	$40	Not Covered
	Non-Preferred Brand – Tier 4	$80	Not Covered
Specialty *Pharmacy/Medical*	*Preferred Specialty – Tier 5*	50%	Not Covered
	Non-Preferred Specialty– Tier 6	50%	Not Covered

This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to your Health Alliance Policy for detailed information regarding this plan.

*Facility coverage only; physicians fees may apply

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 316 Fifth Street, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-851-3379; telephone for members in Washington: 1-877-750-3515 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, 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. IA, IL, IN, OH: Llame 1-800-851-3379, WA Llame: 1-877-750-3515 (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 1-800-851-3379, WA: 呼叫 1-877-750-3515（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-851-3379, WA: Zadzwoń 1-877-750-3515 (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 1-800-851-3379, WA: Gọi 1-877-750-3515 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 IA, IL, IN, OH: 전화 WA: 1-877-750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-851-3379, WA: Вызов 1-877-750-3515 (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 1-800-851-3379, WA: Tumawag 1-877-750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-851-3379، ولاية واشنطن: اتصل بالرقم: 1-877-750-3515 (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 1-800-851-3379, WA: Anruf 1-877-750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-851-3379, WA: Appelez 1-877-750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ 1-800-851-3379, WA: કૉલ 1-877-750-3515 (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。1-800-851-3379 IA, IL, IN, OH: コール 1-877-750-3515 WA: コール（TTY: 711）。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-851-3379, WA: Bel 1-877-750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-851-3379, WA: Виклик 1-877-750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-851-3379, WA: Chiamare 1-877-750-3515 (TTY: 711).