Health Alliance™

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2025 – 12/31/2025**

Federal Employees Health Benefits Program: Standard Option

Coverage for: Self Only, Self Plus One or Self and 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. Please read the FEHB Plan brochure (RI 73-168) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.healthalliance.org, and view the Glossary at https://www.healthalliance.org/documents/1492.You can call 1-800-851-3379 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 Self Only/$750 Self Plus One/ $1,500 Self and Family In-Network $1,500 Self Only/$3,000 Self Plus One/$3,000 Self and 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. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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. Office Visits, Emergency Room, Emergency Medical Transportation, Urgent Care, Prescription Drugs, Routine Prenatal Care, Rehabilitation Services and Preventive Services.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,350 Self Only/$14,700 Self Plus One/$14,700 Self and Family In-Network $14,700 Self Only/$29,400 Self Plus One/$29,400 Self and Family Out of Network	The out-of-pocket limit, or catastrophic maximum, 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 www.healthalliance.org or call 1-800-851-3379 for a list of 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.
Do you need a referral to see a specialist?	Yes.	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an Injury or illness	$30 copay/visit, deductible does not apply	50% coinsurance	————————none————————
	Specialist visit	$60 copay/visit, deductible does not apply	50% coinsurance	————————none————————
	Preventive care/ screening/immu-nization	No charge	50% coinsurance	One preventative visit and/or well woman visit per plan year.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	————————none————————
	Imaging (CT/PET scans,	25% coinsurance	50% coinsurance	Preauthorization is 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/222/2025	Preferred generic and preventive care drugs	$0 copay/prescription, deductible does not apply	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) Copay or Coinsurance applies then the Deductible In-network

	Non-Preferred generic drugs	$10 copay /prescription, deductible does not apply	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) 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 and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Preferred brand name drugs.	$40 copay /prescription, deductible does not apply	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order) 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 and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug..

	Non-Preferred brand name drugs	$140 copay/ prescription, deductible does not apply	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 and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.
	Preferred specialty drugs	$200 copay/ prescription, deductible does not apply	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 and Out-of-Pocket Maximum. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug.

	Non-Preferred specialty drugs	50% coinsurance	50% coinsurance	Preauthorization is required. Copay or Coinsurance applies then the Deductible In-Network 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 and Out-of-Pocket Maximum. 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Preauthorization may be required for certain procedures. Contact Customer Service for detailed information.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$300 copay/visit, deductible does not apply	$300 copay/visit, deductible does not apply	——————none——————
	Emergency medical transportation	$100 copay, deductible does not apply	$100 copay, deductible does not apply	——————none——————
	Urgent care	$60 copay/visit, deductible does not apply	$60 copay/visit, deductible does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	25% coinsurance	50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit, deductible does not apply	50% coinsurance	——————none——————
	Inpatient services	25% coinsurance	50% coinsurance	——————none——————
If you are pregnant	Office visits	$60 copay for routine prenatal care. Deductible does not apply	50% coinsurance	——————none——————
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	——————none——————
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	——————none——————
If you need help	Home health care	25% coinsurance	50% coinsurance	50 visits per condition per calendar year maximum.
	Rehabilitation services	$60 copay/visit, deductible does not apply	50% coinsurance	Preauthorization is required. 60 visits per condition per calendar year maximum.

recovering or have other special health needs	Habilitation services	$60 copay/visit, deductible does not apply	50% coinsurance	60 visits per condition per calendar year maximum.
	Skilled nursing care	25% coinsurance	Not Covered	Preauthorization is required. 75 days per condition per calendar year maximum.
	Durable medical equipment	25% coinsurance	Not Covered	Preauthorization may be required for certain medical equipment. Contact Customer Service for detailed information.
	Hospice services	25% coinsurance	Not Covered	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If your child needs dental or eye care	Children's eye exam	$60 copay/visit, deductible does not apply	50% coinsurance	————————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 plan's FEHB brochure for more information and a list of any other excluded services.)

- Long-term care
- Cosmetic Surgery
- Non-Emergency Care When Traveling Outside the U.S
- Dental care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Weight Loss Programs
- Hearing aids
- Infertility Services
- Routine eye Care (Adult)
- Routine Foot Care
- Private Duty Nursing

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-851-3379 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the

circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-851-3379.
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-onlycoverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible $750**
- **Specialist $60 copay/visit**
- **Hospital (facility) 25% coinsurance**
- **Other 25% coinsurance**

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	$750
Copayments	$60
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

- **The plan's overall deductible $750**
- **Specialist $60 copay/visit**
- **Hospital (facility) 25% coinsurance**
- **Other 25% coinsurance**

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	$750
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	
The total Joe would pay is	**$1,650**

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

- **The plan's overall deductible $750**
- **Specialist $60 copay/visit**
- **Hospital (facility) 25% coinsurance**
- **Other 25% coinsurance**

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	$750
Copayments	$800
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,590**

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 (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). 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 (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822; telephone for members: (800) 851-3379, 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. Llame (800) 851-3379.

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫 (800) 851-3379。

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń (800) 851-3379.

LƯU Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi (800) 851-3379.

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 851-3379로 전화하세요.

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Звоните (800) 851-3379.

Aird: Má tá Gaeilge agat, tá seirbhísí cúnaimh teanga, saor in aisce, ar fáil duit. Glaoigh ar (800) 851-3379.

Aufmerksamkeit: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufen Sie (800) 851-3379.

ATTENTION: Si vous parlez français, des services d'assistance linguistique, gratuits, sont à votre disposition. Appelez le (800) 851-3379.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે [illegible] ઉપલબ્ધ છે. (800) 851-3379 પર કૉલ કરો.

注意: 日本語を話せる場合は、言語支援サービスを無料でご利用いただけます。 (800) 851-3379 に電話してください

LET OP: Als u Nederlands spreekt, zijn er gratis taalhulpdiensten voor u beschikbaar. Bel (800) 851-3379.

УВАГА: Якщо ви володієте українською мовою, вам надаються послуги мовної допомоги, безкоштовні. Телефонуйте (800) 851-3379.

ATTENZIONE: Se parli italiano sono a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il numero (800) 851-3379.