State of Illinois

Member Benefits			Member Responsibility In-Network	Out-of-Network (OON)
Plan Year Deductible	**Medical**	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Pharmacy	Individual	$150	Not Applicable
		Family	Not Applicable	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical & pharmacy expenses including deductible, coinsurance & copayments will not exceed the IRS maximum allowed.	**Medical**	Individual	$3,000	Not Applicable
		Family	$6,000	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per primary medical diagnosis per plan year combined PT/OT/ST	
		Habilitative Services	60 visits per primary medical diagnosis per plan year combined PT/OT/ST	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	Not Covered	Not Covered
		Virtual Visits	$10 per visit	Not Covered
		Primary Care Physician Office Visits	$30 per visit	Not Covered
		Specialty Care Physician Office Visits	$40 per visit	Not Covered
		Chiropractic Services	$35 per visit	Not Covered
		Acupuncture	$25 per visit	Not Covered
		Urgent Care Visits	$30 per visit	$30 per visit
		Allergy Treatment and Testing	$0 per visit	Not Covered
Emergency Services				
		Emergency Department Visits	$275 per visit	$275 per visit
		Emergency Ambulance Transportation	$0 per transport	$0 per transport
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	$300 per procedure	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	0%	Not Covered
		Inpatient Hospitalization Facility Fees	$425 per stay	Not Covered
		Inpatient Physician/Surgeon Fees	0%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services	$40 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	Not Covered
		Home Health	$40 per visit	Not Covered
Diagnostic Services				
		MRI and CT Scans	$30 per service	Not Covered
		Diagnostic Testing Laboratory	$0 per service	Not Covered
		Diagnostic Testing X-Ray	$0 per service	Not Covered
Mental Health/Substance Use Treatment				
		Outpatient Office Visits	$30 per visit	Not Covered
		Inpatient Services	$425 per stay	Not Covered
Prescription Drugs				
30 day supply				
		Reduced Generic Tier 1	$4	Not Covered
		Generic Tier 1	$20	Not Covered
		Preferred Brand - Preferred Specialty Tier 2	$35	Not Covered
		Non-Preferred Brand - Non-Preferred Specialty Tier 3	$60	Not Covered

Member Benefits	In-Network	Out-of-Network (OON)
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, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	$50	Not Covered
Maternity Inpatient	$425 per stay	Not Covered
Newborn Care	$425 per stay	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	Not Covered
Abortion Procedure Facility Fee	$300 per procedure	Not Covered
Abortion Procedure Physician Fee	0%	Not Covered
Durable Medical Equipment	20%	Not Covered

This is a brief statement of Health Alliance **HMO** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **HMO** Policy booklet for more detail about your health plan. This document is in conjunction with the Summary of Benefits and Coverage (SBC). You can view your SBC online at www.healthalliance.org or request a copy by contacting the customer service number on the back of your ID card.