Health Alliance℠

HMO

2018 Large Group Plans
Illinois

Learn more about everything you can give your employees.

Fully Packaged Plans

Section 1

HMO Plans with Rx

If you want a plan with pre-selected pharmacy benefits, we've got you covered. These plans are a convenient way to choose comprehensive coverage for your employees.

Your Choice Medical + Rx Plans

Section 2

Choose Your HMO Plan

Interested in more options? Pick a plan from this section and pair it with any of our pharmacy options for customized coverage.

Section 3

Pair with a Pharmacy Option

Check out what each of our pharmacy options has to offer, and choose one to go with an HMO plan from Section 2.

Health Alliance Earns J.D. Power Award

Health Alliance has earned "Highest Member Satisfaction among Commercial Health Plans in the Illinois/Indiana Region" in the J.D. Power 2017 Member Health Plan Study[SM].

Our commitment to integrated care means seamlessly connecting the doctors, services and treatments our members need, resulting in the high-quality care they deserve.

Health Alliance Medical Plans received the highest numerical score among 8 commercial health plans in the Illinois and Indiana regions in the J.D. Power 2017 Member Health Plan Study, based on 33,624 total responses, measuring experiences and perceptions of members surveyed January 2017–March 2017. Your experiences may vary. Visit jdpower.com.

Care Management

We support our members through every step of care with these programs, included in their coverage at no extra cost.

- Health coaching for encouragement and support in making a healthy lifestyle change.
- Case management when members have a critical medical need or a complex condition and need help navigating the healthcare system. We have doctors, nurses, social workers and others who are plugged in to both the health plan and healthcare providers.
- Care transitions for a smooth adjustment from hospital to home and any stays in between.
- Medication management for help taking medications safely and getting the expected results.

These services are part of what makes Health Alliance more than just healthcare coverage. We're part of your employees' healthcare system and can help them in more ways than you might expect.

Members can learn more about these programs by calling our Quality & Medical Management Department at 1-800-851-3379, ext. 8112.

About Our Plans

HMO

We know employees get sick or hurt, and when they do, they need health care. They can't always avoid the bad stuff life throws at them, but it's nice to help them through it. That's why we're here—to give them insurance for real life.

STRUCTURE

- Only HMO participating care is covered, but at very affordable rates.
- Non-participating care is covered in emergencies or when a referral authorization is given.
- Members choose a primary care provider (PCP) to coordinate all medical care.
- For specialty care, a PCP gives a referral to a participating specialist.
- Women can select a Woman's Principal Healthcare Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

CONSIDERATIONS

A PCP understands the big picture of the member's health and serves as a healthcare partner.

Ask your client consultant for more information on our extended network options for employer groups.

Section

1

Plans with Rx

If you want a plan with pre-selected pharmacy benefits, we've got you covered. These plans are a convenient way to choose comprehensive coverage for your employees.

- Plans with a variety of premium and deductible options
- Many can be paired with a Health Savings Account
- Pre-selected pharmacy coverage
- Non-participating emergency care

The following apply to all fully packaged plans in this section:

- Plans designated with "HSA" can be paired with an employee health savings account.
- Your deductible and copayments/coinsurance, including for pharmacy coverage, all count toward your out-of-pocket maximum.
  - **Out-of-Pocket Maximum—**The most you'll pay out-of-pocket during your plan year. Once you reach this limit, Health Alliance pays 100 percent of covered expenses for the rest of the plan year.
  - **Deductible—**A set amount you pay before your plan starts helping pay for your medical care or pharmacy benefits. Some plans have separate medical and pharmacy deductibles.
  - **Copayment—**A set fee you pay when you use certain medical services covered by your plan.
  - **Coinsurance—**A percentage of the cost you pay when you use certain medical services covered by your plan.
- The HMO plans in this section have either an embedded or aggregate family deductible.
  - With an **embedded deductible**, coverage kicks in for a member of your family as soon as he or she meets the individual deductible, even if the family deductible hasn't been met.
  - With an **aggregate deductible**, coverage kicks in for everyone after the family deductible is met. Even if one person meets his or her individual deductible, coverage won't start until the family deductible is met.
- Preventive and wellness services include immunizations, adult and child annual physical exams, mammograms, Pap smears, cancer screenings and more. Age/frequency restrictions may apply.

HMO Embedded

Member Responsibility

	1200		1600a		2000a	
	Participating	**Non-Participating**	**Participating**	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $1,200 Family: $2,400	Not Applicable Not Applicable	Single: $1,600 Family: $3,200	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $3,600 Family: $7,200	Not Applicable Not Applicable	Single: $4,000 Family: $8,000	Not Applicable Not Applicable	Single: $3,200 Family: $6,400	Not Applicable Not Applicable
Medical Benefits						
Annual Vision Exam	$20	Not Covered	$20	Not Covered	$20	Not Covered
Primary Care Provider Office Visits	$25	Not Covered	$25	Not Covered	$25	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$50	Not Covered	$40	Not Covered
Spinal Manipulations	$50	Not Covered	$50	Not Covered	$40	Not Covered
Urgent Care Visits	$90	$90	$90	$90	deductible, 10%	deductible, 10%^
Emergency Department Visits	deductible, 20%	deductible, 20%^	deductible, 10%	deductible, 10%^	deductible, 10%	deductible, 10%^
Emergency Ambulance Transportation	deductible, 20%	deductible, 20%^	deductible, 10%	deductible, 10%^	deductible, 10%	deductible, 10%^
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$25	Not Covered	$25	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$20	Not Covered	$20	Not Covered	$20	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered	$0	Not Covered
Prescription Drugs						
Generic - Tier 1	$10	Not Covered	$7	Not Covered	$10	Not Covered
Brand - Tier 2	$40	Not Covered	$35	Not Covered	$40	Not Covered
Non-Preferred Brand - Tier 3	$80	Not Covered	$70	Not Covered	$80	Not Covered
Specialty						
Preferred Specialty Pharmacy/Medical - Tier 4	$200	Not Covered	$140	Not Covered	$200	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	$300	Not Covered	$210	Not Covered	$300	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	50%	Not Covered	50%	Not Covered	50%	Not Covered

*Facility coverage only; provider fees may apply. **Newborn covered under mother's policy up to 96 hours. ^In-Network deductible applies.

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

HMO
Embedded

2400a | 2750a

Member Responsibility

	2400a Participating	2400a Non-Participating	2750a Participating	2750a Non-Participating
Plan Year Deductible	Single: $2,400 Family: $4,800	Not Applicable Not Applicable	Single: $2,750 Family: $5,500	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $6,000 Family: $12,000	Not Applicable Not Applicable	Single: $6,400 Family: $12,800	Not Applicable Not Applicable
Medical Benefits				
Annual Vision Exam	$20	Not Covered	$20	Not Covered
Primary Care Provider Office Visits	$30/visit 1-5, ded, 30%	Not Covered	$40/visit 1-5, ded, 50%	Not Covered
Specialty Care Provider Office Visits	$60/visit 1-5, ded, 30%	Not Covered	$80/visit 1-5, ded, 50%	Not Covered
Spinal Manipulations	$60/visit 1-5, ded, 30%	Not Covered	$80/visit 1-5, ded, 50%	Not Covered
Urgent Care Visits	deductible, 30%	deductible, 30%^	deductible, 50%	deductible, 50%^
Emergency Department Visits	deductible, 30%	deductible, 30%^	deductible, 50%	deductible, 50%^
Emergency Ambulance Transportation	deductible, 30%	deductible, 30%^	deductible, 50%	deductible, 50%^
Outpatient Surgery/Procedures*	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$30/visit 1-5, ded, 30%	Not Covered	$40/visit 1-5, ded, 50%	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Routine Prenatal Care	deductible, 30%	Not Covered	deductible, 50%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$20	Not Covered	$20	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered
Prescription Drugs				
Pharmacy Deductible	Single: $250 Family: $500	Single: Not Covered Family: Not Covered	Single: $250 Family: $500	Single: Not Covered Family: Not Covered
Generic - Tier 1	pharmacy deductible, $10	Not Covered	pharmacy deductible, $7	Not Covered
Brand - Tier 2	pharmacy deductible, $40	Not Covered	pharmacy deductible, $35	Not Covered
Non-Preferred Brand - Tier 3	pharmacy deductible, $80	Not Covered	pharmacy deductible, $70	Not Covered
Specialty				
Preferred Specialty Pharmacy/Medical - Tier 4	pharmacy deductible, $200	Not Covered	pharmacy deductible, $140	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	pharmacy deductible, $300	Not Covered	pharmacy deductible, $210	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	pharmacy deductible, 50%	Not Covered	pharmacy deductible, 50%	Not Covered

*Facility coverage only, provider fees may apply. **Newborn covered under mother's policy up to 96 hours. ^In-Network deductible applies.
This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans.

HMO

Aggregate

HSA 1750a

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $1,750 Family: $3,500	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $1,750 Family: $3,500	Not Applicable Not Applicable
Medical Benefits		
Annual Vision Exam	deductible, 0%	Not Covered
Primary Care Provider Office Visits	deductible, 0%	Not Covered
Specialty Care Provider Office Visits	deductible, 0%	Not Covered
Spinal Manipulations	deductible, 0%	Not Covered
Urgent Care Visits	deductible, 0%	deductible, 0%^
Emergency Department Visits	deductible, 0%	deductible, 0%^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0%^
Outpatient Surgery/Procedures*	deductible, 0%	Not Covered
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 0%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	Not Covered
Routine Prenatal Care	deductible, 0%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, 0%	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	Not Covered
Brand - Tier 2	deductible, 0%	Not Covered
Non-Preferred Brand - Tier 3	deductible, 0%	Not Covered
Specialty		
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 0%	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 0%	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 0%	Not Covered

*Facility coverage only, provider fees may apply. **Newborn covered under mother's policy up to 96 hours. ^In-Network deductible applies.

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

HMO Embedded

HSA 3500

HSA 5000a

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $3,500 Family: $7,000	Not Applicable Not Applicable	Single: $5,000 Family: $10,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Not Applicable Not Applicable	Single: $6,250 Family: $12,500	Not Applicable Not Applicable
Medical Benefits				
Annual Vision Exam	deductible, $40	Not Covered	deductible, $40	Not Covered
Primary Care Provider Office Visits	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Specialty Care Provider Office Visits	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Spinal Manipulations	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Urgent Care Visits	deductible, 20%	deductible, 20%^	deductible, 20%	deductible, 20%^
Emergency Department Visits	deductible, 20%	deductible, 20%^	deductible, 20%	deductible, 20%^
Emergency Ambulance Transportation	deductible, 20%	deductible, 20%^	deductible, 20%	deductible, 20%^
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Inpatient Facility* (including Maternity, Newborn** and Mental Health)	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing: *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, $40	Not Covered	deductible, $40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered
Prescription Drugs				
Generic - Tier 1	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Brand - Tier 2	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Non-Preferred Brand - Tier 3	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Specialty				
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 20%	Not Covered	deductible, 20%	Not Covered

*Facility coverage only, provider fees may apply. **Newborn covered under mother's policy up to 96 hours. ^In-Network deductible applies. This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans.

Section 2

Choose Your HMO Plan

Interested in more choices?

Pick a plan from this section and pair it with any of our pharmacy options for customized coverage.

- Traditional HMO plans
- Must pair with one of our pharmacy options (see Section 3)
- Non-participating emergency care

The following apply to all medical plans in this section:

- Plans designated with "HRA" can be paired with a health reimbursement arrangement. If an HRA plan has an out-of-pocket maximum beyond the current Affordable Care Act limits, it must be paired with a health reimbursement arrangement.
- Your deductible and copayments/coinsurance, including for pharmacy coverage, all count toward your out-of-pocket maximum.
  - **Out-of-Pocket Maximum—**The most you'll pay out-of-pocket during your plan year. Once you reach this limit, Health Alliance pays 100 percent of covered expenses for the rest of the plan year.
  - **Deductible—**A set amount you pay before your plan starts helping pay for your medical care or pharmacy benefits. Some plans have separate medical and pharmacy deductibles.
  - **Copayment—**A set fee you pay when you use certain medical services covered by your plan.
  - **Coinsurance—**A percentage of the cost you pay when you use certain medical services covered by your plan.
- The HMO plans in this section have an embedded family deductible.
  - With an **embedded deductible**, coverage kicks in for a member of your family as soon as he or she meets the individual deductible, even if the family deductible hasn't been met.
- Preventive and wellness services include immunizations, adult and child annual physical exams, mammograms, Pap smears, cancer screenings and more. Age/frequency restrictions may apply.

HMO Embedded

Member Responsibility

Member Benefits	100a Participating	100a Non-Participating	90a Participating	90a Non-Participating	80a Participating	80a Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Not Applicable Not Applicable	Single: $0 Family: $0	Not Applicable Not Applicable	Single: $0 Family: $0	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $1,500 Family: $3,000	Not Applicable Not Applicable	Single: $1,500 Family: $3,000	Not Applicable Not Applicable	Single: $1,500 Family: $3,000	Not Applicable Not Applicable
Medical Benefits						
Annual Vision Exam	$40	Not Covered	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	Not Covered	$25	Not Covered	$25	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$50	Not Covered	$50	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$50	$50	$50	$50	$50	$50
Emergency Department Visits	$200	$200	$200	$200	$200	$200
Emergency Ambulance Transportation	$100	$100	$100	$100	$100	$100
Outpatient Surgery/Procedures*	$100	Not Covered	10%	Not Covered	20%	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$50 per day	Not Covered	10%	Not Covered	20%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$25	Not Covered	$25	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	Not Covered	10%	Not Covered	20%	Not Covered
Physical Therapy, Occupational Therapy	$50/visit	Not Covered	10%	Not Covered	20%	Not Covered
Durable Medical Equipment	20%	Not Covered	20%	Not Covered	20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	0%	Not Covered	10%	Not Covered	20%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	$0	Not Covered	10%	Not Covered	20%	Not Covered
Routine Prenatal Care	$100 per pregnancy	Not Covered	10%	Not Covered	20%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered	$40	Not Covered	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preventive Services	$0	Not Covered	$0	Not Covered	$0	Not Covered
Prescription Drugs	See Pharmacy Options, Section 3					

*Facility coverage only; provider fees may apply. **Newborn covered under mother's policy up to 96 hours.

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

HMO

Embedded

	5000a		5000b	
	Member Responsibility			
Member Benefits	**Participating**	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $5,000 Family: $10,000	Not Applicable Not Applicable	Single: $5,000 Family: $10,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $5,500 Family: $11,000	Not Applicable Not Applicable	Single: $5,500 Family: $11,000	Not Applicable Not Applicable
Medical Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visits	$25	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered
Spinal Manipulations	50%	Not Covered	50%	Not Covered
Urgent Care Visits	$50	$50	$80	$80
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Inpatient Facility* (including Maternity, Newborn** and Mental Health)	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Diagnostic Testing: *MRI/CT Scans, X-rays, Lab*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Routine Prenatal Care	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered
Prescription Drugs	See Pharmacy Options, Section 3			

*Facility coverage only; provider fees may apply. **Newborn covered under mother's policy up to 96 hours.

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

HMO Embedded

5000d | 5000e

Member Responsibility

Member Benefits	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $5,000 Family: $10,000	Not Applicable Not Applicable	Single: $5,000 Family: $10,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $6,600 Family: $13,200	Not Applicable Not Applicable	Single: $6,600 Family: $13,200	Not Applicable Not Applicable
Medical Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visits	$25	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered
Spinal Manipulations	50%	Not Covered	50%	Not Covered
Urgent Care Visits	$50	$50	$80	$80
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Inpatient Facility* (including Maternity, Newborn** and Mental Health)	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing: *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered
Prescription Drugs	**See Pharmacy Options, Section 3**			

*Facility coverage only; provider fees may apply. **Newborn covered under mother's policy up to 96 hours.
This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans.

HMO Embedded

6850a

6850b

Member Responsibility

Member Benefits	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $6,850 Family: $13,700	Not Applicable Not Applicable	Single: $6,850 Family: $13,700	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $7,350 Family: $14,700	Not Applicable Not Applicable	Single: $7,350 Family: $14,700	Not Applicable Not Applicable
Medical Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visits	$25	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered
Spinal Manipulations	50%	Not Covered	50%	Not Covered
Urgent Care Visits	$50	$50	$80	$80
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Inpatient Facility* (including Maternity, Newborn** and Mental Health)	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Diagnostic Testing: *MRI/CT Scans, X-rays, Lab*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Routine Prenatal Care	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	Not Covered	$0	Not Covered
Prescription Drugs	See Pharmacy Options, Section 3			

*Facility coverage only; provider fees may apply. **Newborn covered under mother's policy up to 96 hours.
This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans.

Section 3

Pair with a Pharmacy Option

Check out what each of our pharmacy options has to offer, and choose one to go with an HMO medical plan from Section 2.

- Five options to choose from
- Must pair with an HMO plan (see Section 2)

$7/$25/$50/$100/$150/50% Benefit

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$7	Not Covered
Brand - Tier 2	$25	Not Covered
Non-Preferred Brand - Tier 3	$50	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	$100	Not Covered
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$150	Not Covered
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	Not Covered

Rx 1

$7/$35/$70/$140/$210/50% Benefit

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$7	Not Covered
Brand - Tier 2	$35	Not Covered
Non-Preferred Brand - Tier 3	$70	Not Covered
Preferred Specialty Pharmacy/ Medical - Tier 4 *Preauthorization Required*	$140	Not Covered
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$210	Not Covered
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	Not Covered

Rx 2

$10/$40/$80/$200/$300/50% Benefit

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$10	Not Covered
Brand - Tier 2	$40	Not Covered
Non-Preferred Brand - Tier 3	$80	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	$200	Not Covered
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$300	Not Covered
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	Not Covered

Rx 3

$20/$40/$50/20%/20%/20% Benefit

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$20	Not Covered
Brand - Tier 2	$40	Not Covered
Non-Preferred Brand - Tier 3	$50	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	20%	Not Covered
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	20%	Not Covered
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	20%	Not Covered

Rx 8

Lifestyle/erectile dysfunction drug coverage is optional. This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans. If pairing the medical product with an HSA, the medical deductible will apply before the pharmacy copayments. When applicable, out-of-network medical deductible will apply before the pharmacy coinsurance.

$10/$40/$80/30%/40%/50% Benefit

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$10	Not Covered
Brand - Tier 2	$40	Not Covered
Non-Preferred Brand - Tier 3	$80	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	30%	Not Covered
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	40%	Not Covered
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	Not Covered

Rx 65

Lifestyle/erectile dysfunction drug coverage is optional. This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans. If pairing the medical product with an HSA, the medical deductible will apply before the pharmacy copayments. When applicable, out-of-network medical deductible will apply before the pharmacy coinsurance.

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