

# 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<sup>SM</sup>.

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](http://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.

Member Responsibility

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

Member Responsibility

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

Member Responsibility

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

Member Responsibility

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

**Member Responsibility**

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

**Member Responsibility**

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

\*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.

**Member Responsibility**

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

\*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.

## Member Responsibility

Member Benefits	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: \$7,500 Family: \$15,000	Not Applicable Not Applicable	Single: \$7,500 Family: \$15,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: \$8,000 Family: \$16,000	Not Applicable Not Applicable	Single: \$8,000 Family: \$16,000	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.

Member Responsibility

Member Benefits	Participating	Non-Participating	Participating	Non-Participating
<b>Plan Year Deductible</b>	Single: \$10,000 Family: \$20,000	Not Applicable Not Applicable	Single: \$10,000 Family: \$20,000	Not Applicable Not Applicable
<b>Plan Year Out-of-Pocket Maximum</b>	Single: \$10,500 Family: \$21,000	Not Applicable Not Applicable	Single: \$10,500 Family: \$21,000	Not Applicable Not Applicable
<b>Medical Benefits</b>				
<b>Annual Vision Exam</b>	\$40	Not Covered	\$40	Not Covered
<b>Primary Care Provider Office Visits</b>	\$25	Not Covered	\$40	Not Covered
<b>Specialty Care Provider Office Visits</b>	\$50	Not Covered	\$65	Not Covered
<b>Spinal Manipulations</b>	50%	Not Covered	50%	Not Covered
<b>Urgent Care Visits</b>	\$50	\$50	\$80	\$80
<b>Emergency Department Visits</b>	\$200	\$200	\$250	\$250
<b>Emergency Ambulance Transportation</b>	\$100	\$100	\$150	\$150
<b>Outpatient Surgery/Procedures*</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Inpatient Facility*</b> (including Maternity, Newborn** and Mental Health)	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Mental Health/Substance Abuse Outpatient Office Visits</b>	\$25	Not Covered	\$40	Not Covered
<b>Mental Health/Substance Abuse Outpatient Facility Visits*</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Physical Therapy, Occupational Therapy, Durable Medical Equipment</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Arm, Leg Prostheses and Custom Orthotics</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Diagnostic Testing: MRI/CT Scans, X-rays, Lab</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Routine Prenatal Care</b>	deductible, 0%	Not Covered	deductible, 0%	Not Covered
<b>Pediatric Dental Exam for children up to age 19</b>	Not Covered	Not Covered	Not Covered	Not Covered
<b>Pediatric Vision Exam for children up to age 19</b>	\$40	Not Covered	\$40	Not Covered
<b>Pediatric Vision Materials for children up to age 19</b>	Not Covered	Not Covered	Not Covered	Not Covered
<b>Preventive &amp; Wellness Services</b>	\$0	Not Covered	\$0	Not Covered
<b>Prescription Drugs</b>	<b>See Pharmacy Options, Section 3</b>			

\*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.

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)

## Section

3

### Pair with a Pharmacy Option



**\$7/\$25/\$50/\$100/\$150/50% Benefit****\$7/\$35/\$70/\$140/\$210/50% Benefit**

## Member Responsibility

## Member Responsibility

Member Benefits	Participating	Non-Participating	Member Benefits	Participating	Non-Participating
<b>Retail Drugs</b>			<b>Retail Drugs</b>		
Rxtra Drugs	FREE (\$0)	Not Covered	Rxtra Drugs	FREE (\$0)	Not Covered
Generic - Tier 1	\$7	Not Covered	Generic - Tier 1	\$7	Not Covered
Brand - Tier 2	\$25	Not Covered	Brand - Tier 2	\$35	Not Covered
Non-Preferred Brand - Tier 3	\$50	Not Covered	Non-Preferred Brand - Tier 3	\$70	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 <i>Preauthorization Required</i>	\$100	Not Covered	Preferred Specialty Pharmacy/Medical - Tier 4 <i>Preauthorization Required</i>	\$140	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5 <i>Preauthorization Required</i>	\$150	Not Covered	Non-Preferred Specialty Pharmacy/Medical - Tier 5 <i>Preauthorization Required</i>	\$210	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6 <i>Preauthorization Required</i>	50%	Not Covered	Non-Formulary Specialty Pharmacy/Medical - Tier 6 <i>Preauthorization Required</i>	50%	Not Covered

**\$10/\$40/\$80/\$200/\$300/50% Benefit****\$20/\$40/\$50/20%/20%/20% Benefit**

## Member Responsibility

## Member Responsibility

Member Benefits	Participating	Non-Participating	Member Benefits	Participating	Non-Participating
<b>Retail Drugs</b>			<b>Retail Drugs</b>		
Rxtra Drugs	FREE (\$0)	Not Covered	Rxtra Drugs	FREE (\$0)	Not Covered
Generic - Tier 1	\$10	Not Covered	Generic - Tier 1	\$20	Not Covered
Brand - Tier 2	\$40	Not Covered	Brand - Tier 2	\$40	Not Covered
Non-Preferred Brand - Tier 3	\$80	Not Covered	Non-Preferred Brand - Tier 3	\$50	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4 <i>Preauthorization Required</i>	\$200	Not Covered	Preferred Specialty Pharmacy/Medical - Tier 4 <i>Preauthorization Required</i>	20%	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5 <i>Preauthorization Required</i>	\$300	Not Covered	Non-Preferred Specialty Pharmacy/Medical - Tier 5 <i>Preauthorization Required</i>	20%	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6 <i>Preauthorization Required</i>	50%	Not Covered	Non-Formulary Specialty Pharmacy/Medical - Tier 6 <i>Preauthorization Required</i>	20%	Not Covered

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
<b>Retail Drugs</b>		
<b>Rxtra Drugs</b>	FREE (\$0)	Not Covered
<b>Generic - Tier 1</b>	\$10	Not Covered
<b>Brand - Tier 2</b>	\$40	Not Covered
<b>Non-Preferred Brand - Tier 3</b>	\$80	Not Covered
<b>Preferred Specialty Pharmacy/Medical - Tier 4</b> <i>Preauthorization Required</i>	30%	Not Covered
<b>Non-Preferred Specialty Pharmacy/Medical - Tier 5</b> <i>Preauthorization Required</i>	40%	Not Covered
<b>Non-Formulary Specialty Pharmacy/Medical - Tier 6</b> <i>Preauthorization Required</i>	50%	Not Covered

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.

## 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 Medical Plans, Customer Service, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, [CustomerService@healthalliance.org](mailto: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. Llame 1-800-851-3379 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫1-800-851-3379 (TTY: 711)。

Polish: UWAGA: Jeśli mówisz polsku, usługi pomocy językowej, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-851-3379 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-851-3379 (TTY: 711).

주의：당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-851-3379 (TTY: 711).

Pansin: Kung magalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag

1-800-851-3379 (TTY: 711).

مساعدات المساعدة اللغوية العربية، خدمات اللغة العربية: إذا كنت تتحدث اللغة العربية، خدمات المساعدة اللغوية العربية،

Wenn Sie Deutsch sprechen, Sprachassistenten sind kostenlos, zur Verfügung. Anruf 1-800-851-3379 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez

1-800-851-3379 (TTY: 711).

ध्यानः तमे वात ती गुजराती, भाषा सहाय सेवाओं, मफ़्त, तमारी माटे उपलब्ध छे. ड़ेले 1-800-851-3379 (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コール (TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel

1-800-851-3379 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик

1-800-851-3379 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare

1-800-851-3379 (TTY: 711).



