Health Alliance℠

HMO

2017 Large Group Plans
Iowa

Learn more about everything you can give your employees.

Your Choice Medical + Rx Plan

Section 1

Choose Your HMO Plan

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

Section 2

Pair with a Pharmacy Option

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

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

Choose Your HMO Plan

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 2)
- Non-participating emergency care

The following apply to all medical plans in this section:

- 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—**The amount you pay each time you get care covered by your plan (after you meet your deductible).
  - **Coinsurance—**The percentage of the cost you pay each time you get care covered by your plan (after you meet your deductible).
- The HMO plans in this booklet 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

250a 250b 250c

Member Responsibility

	250a Participating	250a Non-Participating	250b Participating	250b Non-Participating	250c Participating	250c Non-Participating
Plan Year Deductible	Single: $250 Family: $500	Not Applicable Not Applicable	Single: $250 Family: $500	Not Applicable Not Applicable	Single: $250 Family: $500	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $1,250 Family: $2,500	Not Applicable Not Applicable	Single: $1,250 Family: $2,500	Not Applicable Not Applicable	Single: $1,250 Family: $2,500	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 10%	Not Covered	deductible, 10%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Routine Prenatal Care	deductible, 10%	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	$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 2					

*Facility coverage only; physician 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

Member Responsibility

	500a		500b		500c	
	Participating	**Non-Participating**	**Participating**	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $500 Family: $1,000	Not Applicable Not Applicable	Single: $500 Family: $1,000	Not Applicable Not Applicable	Single: $500 Family: $1,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $1,500 Family: $3,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 10%	Not Covered	deductible, 10%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 10%	Not Covered	deductible, 10%	Not Covered	deductible, 10%	Not Covered
Routine Prenatal Care	deductible, 10%	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	$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 2**					

*Facility coverage only; physician 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

750a | 750b | 750c

Member Responsibility

	750a Participating	750a Non-Participating	750b Participating	750b Non-Participating	750c Participating	750c Non-Participating
Plan Year Deductible	Single: $750 Family: $1,500	Not Applicable Not Applicable	Single: $750 Family: $1,500	Not Applicable Not Applicable	Single: $750 Family: $1,500	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $1,500 Family: $3,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	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	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 2					

*Facility coverage only; physician 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

1000a | 1000b | 1000c

Member Responsibility

	1000a Participating	1000a Non-Participating	1000b Participating	1000b Non-Participating	1000c Participating	1000c Non-Participating
Plan Year Deductible	Single: $1,000 Family: $2,000	Not Applicable Not Applicable	Single: $1,000 Family: $2,000	Not Applicable Not Applicable	Single: $1,000 Family: $2,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $3,500 Family: $7,000	Not Applicable Not Applicable	Single: $3,500 Family: $7,000	Not Applicable Not Applicable	Single: $3,500 Family: $7,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	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	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 2					

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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

	1500d		1500e		1500f	
	Member Responsibility					
	Participating	**Non-Participating**	**Participating**	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	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
Plan Year Out-of-Pocket Maximum	Single: $4,500 Family: $9,000	Not Applicable Not Applicable	Single: $4,500 Family: $9,000	Not Applicable Not Applicable	Single: $4,500 Family: $9,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	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	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 2					

*Facility coverage only; physician 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

2000d | 2000e | 2000f

Member Responsibility

	2000d Participating	2000d Non-Participating	2000e Participating	2000e Non-Participating	2000f Participating	2000f Non-Participating
Plan Year Deductible	Single: $2,000 Family: $4,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	Not Applicable Not Applicable	Single: $2,000 Family: $4,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $6,000 Family: $12,000	Not Applicable Not Applicable	Single: $6,000 Family: $12,000	Not Applicable Not Applicable	Single: $6,000 Family: $12,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 20%	Not Covered	deductible, 20%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	Not Covered	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Routine Prenatal Care	deductible, 20%	Not Covered	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	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 2					

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HMO Embedded

2500a | 2500b | 2500c

Member Responsibility

	2500a Participating	2500a Non-Participating	2500b Participating	2500b Non-Participating	2500c Participating	2500c Non-Participating
Plan Year Deductible	Single: $2,500 Family: $5,000	Not Applicable Not Applicable	Single: $2,500 Family: $5,000	Not Applicable Not Applicable	Single: $2,500 Family: $5,000	Not Applicable Not Applicable
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Not Applicable Not Applicable	Single: $5,000 Family: $10,000	Not Applicable Not Applicable	Single: $5,000 Family: $10,000	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	$40	Not Covered	$40	Not Covered
Specialty Care Provider Office Visits	$50	Not Covered	$65	Not Covered	$65	Not Covered
Spinal Manipulations	$20	Not Covered	$20	Not Covered	$20	Not Covered
Urgent Care Visits	$40	$40	$80	$80	$80	$80
Emergency Department Visits	$200	$200	$250	$250	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150	$150	$150
Outpatient Surgery/Procedures*	deductible, 30%	Not Covered	deductible, 30%	Not Covered	$250/procedure	Not Covered
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 30%	Not Covered	deductible, 30%	Not Covered	$500/admit	Not Covered
Mental Health/Substance Abuse Outpatient Office Visits	$25	Not Covered	$40	Not Covered	$40	Not Covered
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 30%	Not Covered	deductible, 30%	Not Covered	deductible, 30%	Not Covered
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 30%	Not Covered	deductible, 30%	Not Covered	deductible, 30%	Not Covered
Arm, Leg Prostheses and Custom Orthotics	deductible, 30%	Not Covered	deductible, 30%	Not Covered	deductible, 30%	Not Covered
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 30%	Not Covered	deductible, 30%	Not Covered	deductible, 30%	Not Covered
Routine Prenatal Care	deductible, 30%	Not Covered	deductible, 30%	Not Covered	deductible, 30%	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 2					

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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

Pair with a Pharmacy Option

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

- Five options to choose from
- Must pair with an HMO plan (see Section 1)

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

Member Benefits	Member Responsibility: Participating	Member Responsibility: Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	Not Covered
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

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

Member Benefits	Member Responsibility: Participating	Member Responsibility: Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	Not Covered
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

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

Member Benefits	Member Responsibility: Participating	Member Responsibility: Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	Not Covered
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

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

Member Benefits	Member Responsibility: Participating	Member Responsibility: Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	Not Covered
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

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		
Rxtra Drugs	FREE ($0)	Not Covered
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

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.

Health Alliance℠

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. 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.

Spanish

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-851-3379 (TTY: 711).

Chinese

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 mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-851-3379 (TTY: 711).

Vietnamese

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).

Korean

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

Russian

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

Tagalog

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-851-3379 (TTY: 711).

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء 1-800-851-3379 (TTY: 711).

German

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

French

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-851-3379 (TTY: 711).

Gujarati

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 1-800-851-3379 (TTY: 711).

Japanese

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）。

Pennsylvania Dutch

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-851-3379 (TTY: 711).

Ukrainian

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-851-3379 (TTY: 711).

Italian

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-851-3379 (TTY: 711).