Health Alliance℠

POS-C

Plans for 2017
Illinois

Learn more about everything you can give your employees.

Your Choice Medical + Rx Plan

Section 1

Choose Your POS-C 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 offer, and choose one to go with your POS-C plan.

About Our Plans

POS-C

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

- Coverage is determined at the point of service, depending on the provider chosen. When choosing a non-participating provider, indemnity benefits apply, except in emergencies or when a referral authorization is given.
- Members select a primary care provider (PCP) to coordinate all medical care.
- For participating specialty care, a PCP gives a referral to a Health Alliance participating specialist. Specialty care sought without a referral or from a non-participating provider is covered at the lower (indemnity) level.
- Women can select a Woman's Principal Healthcare Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

CONSIDERATIONS

- Premium rates for POS-C plans are very competitive, though copayments are higher than traditional POS plans for some services.
- This product is a combination of HMO financial advantages and the choice of non-participating care covered at a limited (indemnity) level.
- Seeking care from participating providers is vital to POS-C cost effectiveness. Health Alliance has discounts with those providers, allowing us to pass significant savings on to employers.
- Ask your client consultant for more information on our extended network options for employers.

Section 1

Choose Your POS-C Plan

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

- Traditional POS-C plans
- Non-participating emergency care
- Must pair with one of our pharmacy options (see Section 2)

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 POS-C 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.

POS-C Embedded

250a

250b

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $2,250 Family: $4,500	Single: $10,000 Family: $20,000	Single: $2,250 Family: $4,500	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%†	50%	50%†
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$250 per procedure, then 30%	deductible, 50%	$250 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$250 per admit, then 30%	deductible, 50%	$250 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$250 per procedure, then 30%	deductible, 50%	$250 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C Embedded

250d | 250e

Member Responsibility

	250d Participating	250d Non-Participating	250e Participating	250e Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $2,250 Family: $4,500	Single: $10,000 Family: $20,000	Single: $2,250 Family: $4,500	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%†	50%	50%†
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$250 per procedure, then 20%	deductible, 50%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$250 per admit, then 20%	deductible, 50%	$250 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%	20%	deductible, 50%
MRI/CT Scans	$250 per procedure, then 20%	deductible, 50%	$250 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%	20%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C
Embedded

500a
Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $2,500 Family: $5,000	Single: $10,000 Family: $20,000
Member Benefits		
Annual Vision Exam	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%
Spinal Manipulations	50%	50%
Urgent Care Visits	$50	deductible, 50%
Emergency Department Visits	$200	$200
Emergency Ambulance Transportation	$100	$100
Outpatient Surgery/Procedures*	$500 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)***	$500 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%
MRI/CT Scans	$500 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	$0	deductible, 50%
Prescription Drugs	**See Pharmacy Options, Section 2**	

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C
Embedded

500d / 500e

Member Responsibility

	500d Participating	500d Non-Participating	500e Participating	500e Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $2,500 Family: $5,000	Single: $10,000 Family: $20,000	Single: $2,500 Family: $5,000	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%†	50%	50%†
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$500 per procedure, then 20%	deductible, 50%	$500 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$500 per admit, then 20%	deductible, 50%	$500 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%	20%	deductible, 50%
MRI/CT Scans	$500 per procedure, then 20%	deductible, 50%	$500 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%	20%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C
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1000a

1000b

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$1,000 per procedure, then 30%	deductible, 50%	$1,000 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$1,000 per admit, then 30%	deductible, 50%	$1,000 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$500 per procedure, then 30%	deductible, 50%	$500 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C
Embedded

1000d
Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits		
Annual Vision Exam	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%
Spinal Manipulations	50%	50%†
Urgent Care Visits	$50	deductible, 50%
Emergency Department Visits	$200	$200
Emergency Ambulance Transportation	$100	$100
Outpatient Surgery/Procedures*	$1,000 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$1,000 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%
MRI/CT Scans	$500 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	$0	deductible, 50%
Prescription Drugs		**See Pharmacy Options, Section 2**

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C Embedded

1500a 1500b

Member Responsibility

	1500a Participating	1500a Non-Participating	1500b Participating	1500b Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$1,500 per procedure, then 30%	deductible, 50%	$1,500 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$1,500 per admit, then 30%	deductible, 50%	$1,500 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$750 per procedure, then 30%	deductible, 50%	$750 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C Embedded

1500d

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits		
Annual Vision Exam	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%
Spinal Manipulations	50%	50%+
Urgent Care Visits	$50	deductible, 50%
Emergency Department Visits	$200	$200
Emergency Ambulance Transportation	$100	$100
Outpatient Surgery/Procedures*	$1,500 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$1,500 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%
MRI/CT Scans	$750 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	$0	deductible, 50%
Prescription Drugs	**See Pharmacy Options, Section 2**	

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C Embedded

	1500g		1500h	
	Member Responsibility			
	Participating	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $0 Family: $0	Single: $8,000 Family: $16,000	Single: $0 Family: $0	Single: $8,000 Family: $16,000
Plan Year Out-of-Pocket Maximum	Single: $4,000 Family: $8,000	Single: $16,000 Family: $32,000	Single: $4,000 Family: $8,000	Single: $16,000 Family: $32,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%†	50%	50%†
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$1,500 per procedure, then 30%	deductible, 50%	$1,500 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)***	$1,500 per admit, then 30%	deductible, 50%	$1,500 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$750 per procedure, then 30%	deductible, 50%	$750 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C
Embedded

1500j 1500k

Member Responsibility

	1500j Participating	1500j Non-Participating	1500k Participating	1500k Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $8,000 Family: $16,000	Single: $0 Family: $0	Single: $8,000 Family: $16,000
Plan Year Out-of-Pocket Maximum	Single: $4,000 Family: $8,000	Single: $16,000 Family: $32,000	Single: $4,000 Family: $8,000	Single: $16,000 Family: $32,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$1,500 per procedure, then 20%	deductible, 50%	$1,500 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)***	$1,500 per admit, then 20%	deductible, 50%	$1,500 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%	20%	deductible, 50%
MRI/CT Scans	$750 per procedure, then 20%	deductible, 50%	$750 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%	20%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C Embedded

2000a 2000b

Member Responsibility

	2000a Participating	2000a Non-Participating	2000b Participating	2000b Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%†	50%	50%†
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$2,000 per procedure, then 30%	deductible, 50%	$2,000 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$2,000 per admit, then 30%	deductible, 50%	$2,000 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$1,000 per procedure, then 30%	deductible, 50%	$1,000 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. †Deductible does not apply.

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.

POS-C Embedded

2000d | 2000e

Member Responsibility

	2000d Participating	2000d Non-Participating	2000e Participating	2000e Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $5,000 Family: $10,000	Single: $0 Family: $0	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$2,000 per procedure, then 20%	deductible, 50%	$2,000 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)***	$2,000 per admit, then 20%	deductible, 50%	$2,000 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%	20%	deductible, 50%
MRI/CT Scans	$1,000 per procedure, then 20%	deductible, 50%	$1,000 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%	20%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C Embedded

2000g 2000h

Member Responsibility

	2000g Participating	2000g Non-Participating	2000h Participating	2000h Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $10,000 Family: $20,000	Single: $0 Family: $0	Single: $10,000 Family: $20,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $20,000 Family: $40,000	Single: $5,000 Family: $10,000	Single: $20,000 Family: $60,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$2,000 per procedure, then 30%	deductible, 50%	$2,000 per procedure, then 30%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)***	$2,000 per admit, then 30%	deductible, 50%	$2,000 per admit, then 30%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	30%	deductible, 50%	30%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	30%	deductible, 50%	30%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	30%	deductible, 50%	30%	deductible, 50%
MRI/CT Scans	$1,000 per procedure, then 30%	deductible, 50%	$1,000 per procedure, then 30%	deductible, 50%
X-rays, Lab	30%	deductible, 50%	30%	deductible, 50%
Routine Prenatal Care	30%	deductible, 50%	30%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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.

POS-C Embedded

2000j | 2000k

Member Responsibility

	2000j Participating	2000j Non-Participating	2000k Participating	2000k Non-Participating
Plan Year Deductible	Single: $0 Family: $0	Single: $10,000 Family: $20,000	Single: $0 Family: $0	Single: $10,000 Family: $20,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $20,000 Family: $40,000	Single: $5,000 Family: $10,000	Single: $20,000 Family: $40,000
Member Benefits				
Annual Vision Exam	$40	Not Covered	$40	Not Covered
Primary Care Provider Office Visit	$25	deductible, 50%	$40	deductible, 50%
Specialty Care Provider Office Visits	$50	deductible, 50%	$65	deductible, 50%
Spinal Manipulations	50%	50%+	50%	50%+
Urgent Care Visits	$50	deductible, 50%	$80	deductible, 50%
Emergency Department Visits	$200	$200	$250	$250
Emergency Ambulance Transportation	$100	$100	$150	$150
Outpatient Surgery/Procedures*	$2,000 per procedure, then 20%	deductible, 50%	$2,000 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	$2,000 per admit, then 20%	deductible, 50%	$2,000 per admit, then 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	20%	deductible, 50%	20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	20%	deductible, 50%	20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	20%	deductible, 50%	20%	deductible, 50%
MRI/CT Scans	$1,000 per procedure, then 20%	deductible, 50%	$1,000 per procedure, then 20%	deductible, 50%
X-rays, Lab	20%	deductible, 50%	20%	deductible, 50%
Routine Prenatal Care	20%	deductible, 50%	20%	deductible, 50%
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 and Wellness Services	$0	deductible, 50%	$0	deductible, 50%
Prescription Drugs	See Pharmacy Options, Section 2			

*Facility coverage only; physician fees may apply. **Newborn covered under mother's policy up to 96 hours. +Deductible does not apply.

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 a POS-C plan from Section 2.

- Five options to choose from
- Must pair with a POS-C plan (see Section 1)

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

Rx 1

Member Benefits	Member Responsibility Participating	Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	deductible, 50%
Generic - Tier 1	$7	deductible, 50%
Brand - Tier 2	$25	deductible, 50%
Non-Preferred Brand - Tier 3	$50	deductible, 50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	$100	deductible, 50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$150	deductible, 50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	deductible, 50%

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

Rx 2

Member Benefits	Member Responsibility Participating	Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	deductible, 50%
Generic - Tier 1	$7	deductible, 50%
Brand - Tier 2	$35	deductible, 50%
Non-Preferred Brand - Tier 3	$70	deductible, 50%
Preferred Specialty Pharmacy/ Medical - Tier 4 *Preauthorization Required*	$140	deductible, 50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$210	deductible, 50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	deductible, 50%

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

Rx 3

Member Benefits	Member Responsibility Participating	Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	deductible, 50%
Generic - Tier 1	$10	deductible, 50%
Brand - Tier 2	$40	deductible, 50%
Non-Preferred Brand - Tier 3	$80	deductible, 50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	$200	deductible, 50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	$300	deductible, 50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	deductible, 50%

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

Rx 8

Member Benefits	Member Responsibility Participating	Non-Participating
Retail Drugs		
Rxtra Drugs	FREE ($0)	deductible, 50%
Generic - Tier 1	$20	deductible, 50%
Brand - Tier 2	$40	deductible, 50%
Non-Preferred Brand - Tier 3	$50	deductible, 50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	20%	deductible, 50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	20%	deductible, 50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	20%	deductible, 50%

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)	deductible, 50%
Generic - Tier 1	$10	deductible, 50%
Brand - Tier 2	$40	deductible, 50%
Non-Preferred Brand - Tier 3	$80	deductible, 50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	30%	deductible, 50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	40%	deductible, 50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	deductible, 50%

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

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- 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).

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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).

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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).

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Italian

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