Health Alliance℠

POS

2018 Large Group Plans
Illinois and Iowa

Learn more about everything you can give your employees.

Fully Packaged Plans

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.

Your Choice Medical + Rx Plan

Section 2

Choose Your POS 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 a POS 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℠.

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

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

Care Management

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

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

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

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

Virtual Visits Now Covered

Health Alliance members can now interact with a doctor or counselor 24 hours a day, 365 days a year – from their home, office or on the go. This service includes access to U.S. board-certified doctors and licensed counselors with an average of 15 years of experience, private and secure consultations and prescriptions sent to the member's nearest in-network pharmacy.

Many plans now include three virtual visits with a provider for $0.* Visits four and beyond have the same copay or coinsurance as a primary care provider (PCP) office visit.

The Virtual Visit providers can treat a wide range of conditions.

General Health: acne, allergies, cold/flu, constipation, diarrhea, ear infections, fever, headache, nausea/vomiting, rash, sore throats, vaginitis and more.

Behavioral Health: addictions, depression, eating disorders, transgender issues, grief and loss, panic disorders, stress, trauma, PTSD and more.

For more information, call 1-888-912-0904 or visit MDLIVE.com/hacare.

Virtual Visits are available for new Large Groups on July 1, 2018, and all existing Large Groups upon renewal thereafter.

*HSA plans are excluded from the three $0 visits. HSA members will need to meet their deductible first before the PCP copayment applies.

About Our Plans

POS

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, dependent on the provider chosen. When choosing a Health Alliance network provider, HMO-style benefits apply. When choosing a non-participating provider, indemnity benefits apply (except in emergencies, as defined by law).
- Members select a primary care provider (PCP) to coordinate all medical care.
- For participating specialty care, a PCP gives a referral to a participating specialist. Specialty care received 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

- POS plans are a combination of HMO financial advantages with non-participating provider benefits at a limited (indemnity) coverage level.
- Members have the freedom to go out-of-network but can save money when staying in-network. Our network is extensive and features premier providers.
- 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 employers.

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 provider network 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 POS 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.

POS

Embedded

	800a		1200	
	Member Responsibility			
	Participating	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $800 Family: $1,600	Single: $1,600 Family: $3,200	Single: $1,200 Family: $2,400	Single: $2,400 Family: $4,800
Plan Year Out-of-Pocket Maximum	Single: $3,500 Family: $7,000	Single: $7,000 Family: $14,000	Single: $4,000 Family: $8,000	Single: $8,000 Family: $16,000
Medical Benefits				
Annual Vision Exam	$20	Not Covered	$20	Not Covered
Primary Care Provider Office Visits	$20	deductible, 40%	$20	deductible, 40%
Specialty Care Provider Office Visits	$40	deductible, 40%	$40	deductible, 40%
Spinal Manipulations	$40	$40	$40	$40
Urgent Care Visits	$75	$75	$90	$90
Emergency Department Visits	deductible, 20%	deductible, 20% ^	deductible, 20%	deductible, 20% ^
Emergency Ambulance Transportation	deductible, 20%	deductible, 20% ^	deductible, 20%	deductible, 20% ^
Outpatient Surgery/Procedures*	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Mental Health/Substance Abuse Outpatient Office Visits	$20	deductible, 40%	$20	deductible, 40%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Routine Prenatal Care	deductible, 20%	deductible, 40%	deductible, 20%	deductible, 40%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	$20	Not Covered	$20	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Preventive & Wellness Services	$0	deductible, 40%	$0	deductible, 40%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $20	Not Covered	first 3 visits $0, then $20	Not Covered
Prescription Drugs				
Generic - Tier 1	$10	deductible, 50%	$10	deductible, 50%
Brand - Tier 2	$40	deductible, 50%	$40	deductible, 50%
Non-Preferred Brand - Tier 3	$80	deductible, 50%	$80	deductible, 50%
Specialty				
Preferred Specialty Pharmacy/Medical - Tier 4	$200	deductible, 50%	$200	deductible, 50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	$300	deductible, 50%	$300	deductible, 50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	50%	deductible, 50%	50%	deductible, 50%

*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.

POS Embedded

6250

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $6,250 Family: $12,500	Single: $12,500 Family: $25,000
Plan Year Out-of-Pocket Maximum	Single: $6,250 Family: $12,500	Single: $37,500 Family: $75,000
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	deductible, 0%	deductible, 0% ^
Outpatient Surgery/Procedures*	deductible, 0%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 50%
Routine Prenatal Care	deductible, 0%	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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered
Prescription Drugs		
Generic - Tier 1	$20	deductible, 50%
Brand - Tier 2	$40	deductible, 50%
Non-Preferred Brand - Tier 3	$50	deductible, 50%
Specialty		
Preferred Specialty Pharmacy/Medical - Tier 4	20%	deductible, 50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	20%	deductible, 50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	20%	deductible, 50%

*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.

POS Aggregate

HSA 1750a

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $1,750 Family: $3,500	Single: $3,500 Family: $7,000
Plan Year Out-of-Pocket Maximum	Single: $1,750 Family: $3,500	Single: $9,500 Family: $19,000
Medical Benefits		
Annual Vision Exam	deductible, 0%	Not Covered
Primary Care Provider Office Visits	deductible, 0%	deductible, 50%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 50%
Spinal Manipulations	deductible, 0%	deductible, 0% ^
Urgent Care Visits	deductible, 0%	deductible, 50%
Emergency Department Visits	deductible, 0%	deductible, 0% ^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0% ^
Outpatient Surgery/Procedures*	deductible, 0%	deductible, 50%
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 50%
Routine Prenatal Care	deductible, 0%	deductible, 50%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, 0%	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive & Wellness Services	0%	deductible, 50%
Virtual Visits *(see page 3 for more information)*	deductible, 0%	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%
Non-Preferred Brand - Tier 3	deductible, 0%	deductible, 50%
Specialty		
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 0%	deductible, 50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 0%	deductible, 50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 0%	deductible, 50%

*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.

POS Aggregate

HSA 2000

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $2,000 Family: $4,000	Single: $4,000 Family: $12,000
Plan Year Out-of-Pocket Maximum	Single: $2,000 Family: $4,000	Single: $8,000 Family: $24,000
Member Benefits		
Annual Vision Exam	deductible, 0%	Not Covered
Primary Care Provider Office Visit	deductible, 0%	deductible, 20%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 20%
Spinal Manipulations	deductible, 0%	deductible, 0% ^
Urgent Care Visits	deductible, 0%	deductible, 20%
Emergency Department Visits	deductible, 0%	deductible, 0% ^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0% ^
Outpatient Surgery/Procedures*	deductible, 0%	deductible, 20%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 20%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 20%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 20%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 20%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 20%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 20%
Routine Prenatal Care	deductible, 0%	deductible, 20%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, 0%	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	0%	deductible, 20%
Virtual Visits *(see page 3 for more information)*	deductible, 0%	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	deductible, 20%
Brand - Tier 2	deductible, 0%	deductible, 20%
Non-Preferred Brand - Tier 3	deductible, 0%	deductible, 20%
Specialty		
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 0%	deductible, 20%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 0%	deductible, 20%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 0%	deductible, 20%

*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.

POS Embedded

HSA 2700a

HSA 2700b

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $2,700 Family: $5,400	Single: $5,400 Family: $16,200	Single: $2,700 Family: $5,400	Single: $5,400 Family: $16,200
Plan Year Out-of-Pocket Maximum	Single: $2,700 Family: $5,400	Single: $9,000 Family: $27,000	Single: $5,400 Family: $10,800	Single: $10,800 Family: $32,400
Member Benefits				
Annual Vision Exam	deductible, 0%	Not Covered	deductible, 20%	Not Covered
Primary Care Provider Office Visit	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Spinal Manipulations	deductible, 0%	deductible, 0% ^	deductible, 20%	deductible, 20% ^
Urgent Care Visits	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Emergency Department Visits	deductible, 0%	deductible, 0% ^	deductible, 20%	deductible, 20% ^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0% ^	deductible, 20%	deductible, 20% ^
Outpatient Surgery/Procedures*	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Routine Prenatal Care	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, 0%	Not Covered	deductible, 20%	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, 20%	0%	deductible, 40%
Virtual Visits *(see page 3 for more information)*	deductible, 0%	Not Covered	deductible, 20%	Not Covered
Prescription Drugs				
Generic - Tier 1	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Brand - Tier 2	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Non-Preferred Brand - Tier 3	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Specialty				
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 0%	deductible, 20%	deductible, 20%	deductible, 40%

*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.

POS Embedded

HSA 3500 | HSA 4000

Member Responsibility

	HSA 3500 Participating	HSA 3500 Non-Participating	HSA 4000 Participating	HSA 4000 Non-Participating
Plan Year Deductible	Single: $3,500 Family: $7,000	Single: $7,000 Family: $21,000	Single: $4,000 Family: $8,000	Single: $8,000 Family: $24,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $10,000 Family: $30,000	Single: $6,650 Family: $13,300	Single: $12,500 Family: $39,900
Member Benefits				
Annual Vision Exam	deductible, $40	Not Covered	deductible, 20%	Not Covered
Primary Care Provider Office Visit	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Specialty Care Provider Office Visits	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Spinal Manipulations	deductible, 20%	deductible, 20% ^	deductible, 20%	deductible, 20% ^
Urgent Care Visits	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Emergency Department Visits	deductible, 20%	deductible, 20% ^	deductible, 20%	deductible, 20% ^
Emergency Ambulance Transportation	deductible, 20%	deductible, 20% ^	deductible, 20%	deductible, 20% ^
Outpatient Surgery/Procedures*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, $40	Not Covered	deductible, 20%	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, 40%
Virtual Visits *(see page 3 for more information)*	deductible, 20%	Not Covered	deductible, 20%	Not Covered
Prescription Drugs				
Generic - Tier 1	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Brand - Tier 2	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Non-Preferred Brand - Tier 3	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Specialty				
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 40%

*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.

POS Embedded

HSA 5000c

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $5,000 Family: $10,000	Single: $10,000 Family: $30,000
Plan Year Out-of-Pocket Maximum	Single: $6,250 Family: $12,500	Single: $12,350 Family: $37,500
Member Benefits		
Annual Vision Exam	deductible, $40	Not Covered
Primary Care Provider Office Visit	deductible, 20%	deductible, 50%
Specialty Care Provider Office Visits	deductible, 20%	deductible, 50%
Spinal Manipulations	deductible, 20%	deductible, 20% ^
Urgent Care Visits	deductible, 20%	deductible, 50%
Emergency Department Visits	deductible, 20%	deductible, 20% ^
Emergency Ambulance Transportation	deductible, 20%	deductible, 20% ^
Outpatient Surgery/Procedures*	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 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	deductible, $40	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	$0	deductible, 50%
Virtual Visits *(see page 3 for more information)*	deductible, 20%	Not Covered
Prescription Drugs		**See Pharmacy Options, Section 3**
Generic - Tier 1	deductible, 20%	deductible, 50%
Brand - Tier 2	deductible, 20%	deductible, 50%
Non-Preferred Brand - Tier 3	deductible, 20%	deductible, 50%
Specialty		
Preferred Specialty Pharmacy/Medical - Tier 4	deductible, 20%	deductible, 50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	deductible, 20%	deductible, 50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	deductible, 20%	deductible, 50%

*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.

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

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

Section 2

Choose Your POS Plan

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.
- 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 POS 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.

POS Embedded

1000d 1000e

Member Responsibility

	1000d Participating	1000d Non-Participating	1000e Participating	1000e Non-Participating
Plan Year Deductible	Single: $1,000 Family: $2,000	Single: $2,000 Family: $6,000	Single: $1,000 Family: $2,000	Single: $2,000 Family: $6,000
Plan Year Out-of-Pocket Maximum	Single: $3,500 Family: $7,000	Single: $14,000 Family: $32,000	Single: $3,500 Family: $7,000	Single: $14,000 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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

	1500a		1500b	
	Member Responsibility			
	Participating	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $1,500 Family: $3,000	Single: $3,000 Family: $9,000	Single: $1,500 Family: $3,000	Single: $3,000 Family: $9,000
Plan Year Out-of-Pocket Maximum	Single: $4,000 Family: $8,000	Single: $15,000 Family: $35,000	Single: $4,000 Family: $8,000	Single: $15,000 Family: $35,000
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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

2000a | 2000b

Member Responsibility

	2000a Participating	2000a Non-Participating	2000b Participating	2000b Non-Participating
Plan Year Deductible	Single: $2,000 Family: $4,000	Single: $4,000 Family: $12,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $12,000
Plan Year Out-of-Pocket Maximum	Single: $4,500 Family: $9,000	Single: $18,000 Family: $40,000	Single: $4,500 Family: $9,000	Single: $18,000 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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

2500d 2500e

Member Responsibility

	2500d Participating	2500d Non-Participating	2500e Participating	2500e Non-Participating
Plan Year Deductible	Single: $2,500 Family: $5,000	Single: $5,000 Family: $15,000	Single: $2,500 Family: $5,000	Single: $5,000 Family: $15,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $20,000 Family: $45,000	Single: $5,000 Family: $10,000	Single: $20,000 Family: $45,000
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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

4000d 4000e

Member Responsibility

	4000d Participating	4000d Non-Participating	4000e Participating	4000e Non-Participating
Plan Year Deductible	Single: $4,000 Family: $8,000	Single: $8,000 Family: $24,000	Single: $4,000 Family: $8,000	Single: $8,000 Family: $24,000
Plan Year Out-of-Pocket Maximum	Single: $6,600 Family: $13,200	Single: $25,000 Family: $75,000	Single: $6,600 Family: $13,200	Single: $25,000 Family: $75,000
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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

5000d 5000e

Member Responsibility

	5000d Participating	5000d Non-Participating	5000e Participating	5000e Non-Participating
Plan Year Deductible	Single: $5,000 Family: $10,000	Single: $10,000 Family: $30,000	Single: $5,000 Family: $10,000	Single: $10,000 Family: $30,000
Plan Year Out-of-Pocket Maximum	Single: $6,600 Family: $13,200	Single: $30,000 Family: $80,000	Single: $6,600 Family: $13,200	Single: $30,000 Family: $80,000
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*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 20%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 20%	deductible, 50%	deductible, 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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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.

POS Embedded

7350

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $7,350 Family: $14,700	Single: $14,700 Family: $29,400
Plan Year Out-of-Pocket Maximum	Single: $7,350 Family: $14,700	Single: $44,100 Family: $88,200
Member Benefits		
Annual Vision Exam	deductible, 0%	Not Covered
Primary Care Provider Office Visit	deductible, 0%	deductible, 20%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 20%
Spinal Manipulations	deductible, 0%	deductible, 0% ^
Urgent Care Visits	deductible, 0%	deductible, 20%
Emergency Department Visits	deductible, 0%	deductible, 0% ^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0% ^
Outpatient Surgery/Procedures*	deductible, 0%	deductible, 20%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 20%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 20%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 20%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 20%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 20%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 20%
Routine Prenatal Care	deductible, 0%	deductible, 20%
Pediatric Dental Exam for children up to age 19	Not Covered	Not Covered
Pediatric Vision Exam for children up to age 19	deductible, 0%	Not Covered
Pediatric Vision Materials for children up to age 19	Not Covered	Not Covered
Preventive and Wellness Services	0%	deductible,20%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then deductible, 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. ^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.

POS Embedded

6850a 6850b

Member Responsibility

	6850a Participating	6850a Non-Participating	6850b Participating	6850b Non-Participating
Plan Year Deductible	Single: $6,850 Family: $13,700	Single: $15,000 Family: $45,000	Single: $6,850 Family: $13,700	Single: $15,000 Family: $45,000
Plan Year Out-of-Pocket Maximum	Single: $7,350 Family: $14,700	Single: $45,000 Family: $120,000	Single: $7,350 Family: $14,700	Single: $45,000 Family: $120,000
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*	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	deductible, 50%	$40	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Routine Prenatal Care	deductible, 0%	deductible, 50%	deductible, 0%	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%
Virtual Visits *(see page 3 for more information)*	first 3 visits $0, then $25	Not Covered	first 3 visits $0, then $40	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. ^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 3

Pair with a Pharmacy Option

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

- Five options to choose from
- Must pair with a POS plan (see Section 2)

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

Rx 1

Member Benefits	Member Responsibility: Participating	Member Responsibility: Non-Participating
Retail Drugs		
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	Member Responsibility: Non-Participating
Retail Drugs		
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	Member Responsibility: Non-Participating
Retail Drugs		
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	Member Responsibility: Non-Participating
Retail Drugs		
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		
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.

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, 3310 Fields South Drive, Champaign, IL 61822, telephone: 1-800-851-3379, TTY: 711, fax: 217-902-9705, 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: Je li mówi Polskie, usługi pomocy j zyka, bezpłatnie, s dost pne dla Ciebie. Zadzwo 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 magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-851-3379 (TTY: 711).
تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء 1-800-851-3379 (TTY: 711).
Wenn Sie Deutsch sprechen, Sprachassistenzdienste 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).
ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 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).