Health Alliance℠

PPO

2018 Large Group Plans
Illinois and Iowa

Learn more about everything you can give your employees.

Fully Packaged Plans

Section 1

PPO Plans with Rx

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

Your Choice Medical + Rx Plans

Section 2

Choose Your PPO 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 PPO 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

PPO

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

PPO members can see any provider, but they'll get the greatest out-of-pocket savings when staying in the Participating network. Members are not required to select a primary care provider (PCP) to coordinate care.

Health Alliance does not require PPO members to get a referral for specialty care, although some provider practices may require it.

CONSIDERATIONS

Health Alliance has a strong network of top-notch doctors, hospitals, clinics and pharmacies throughout Illinois and Iowa.

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

Section

1

Plans with Rx

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

- Pre-selected pharmacy coverage
- Plans with a variety of premium and deductible options
- Can be paired with a Health Savings Account

The following apply to all fully packaged plans:

- Plans designated with "HSA" can be paired with an employee health savings account.
- Plans designated with "HRA" can be paired with a health reimbursement arrangement. If an HRA plan has an out-of-pocket maximum beyond the current Affordable Care Act limits, it must be paired with a health reimbursement arrangement.
- Your deductible and copayments/coinsurance, including for pharmacy coverage, all count toward your out-of-pocket maximum.
    - **Out-of-Pocket Maximum—**The most you'll pay out-of-pocket during your plan year. Once you reach this limit, Health Alliance pays 100 percent of covered expenses for the rest of the plan year.
    - **Deductible—**A set amount you pay before your plan starts helping pay for your medical care or pharmacy benefits. Some plans have separate medical and pharmacy deductibles.
    - **Copayment—**A set fee you pay when you use certain medical services covered by your plan.
    - **Coinsurance—**A percentage of the cost you pay when you use certain medical services covered by your plan.
- The PPO 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.

PPO Aggregate	HSA 1500a		HSA 1500b	
	Member Responsibility			
	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000
Plan Year Out-of-Pocket Maximum	Single: $1,500 Family: $3,000	Single: $8,000 Family: $16,000	Single: $3,000 Family: $6,000	Single: $8,000 Family: $16,000
Medical Benefits				
Annual Vision Exam	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Primary Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Spinal Manipulations	deductible, 0%	deductible, 0% ^	deductible, 20%	deductible, 20% ^
Urgent Care Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
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, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 0%	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	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
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)*	deductible, 0%	Not Covered	deductible, 20%	Not Covered
Prescription Drugs				
Generic - Tier 1	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Specialty Prescription Drugs	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%

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

PPO

Aggregate

HSA 2000a

HSA 2500g

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000	Single: $2,500 Family: $5,000	Single: $5,000 Family: $10,000
Plan Year Out-of-Pocket Maximum	Single: $2,000 Family: $4,000	Single: $10,000 Family: $20,000	Single: $2,500 Family: $5,000	Single: $10,000 Family: $20,000
Medical Benefits				
Annual Vision Exam	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Primary Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Spinal Manipulations	deductible, 0%	deductible, 0% ^	deductible, 0%	deductible, 0% ^
Urgent Care Visits	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Emergency Department Visits	deductible, 0%	deductible, 0% ^	deductible, 0%	deductible, 0% ^
Emergency Ambulance Transportation	deductible, 0%	deductible, 0% ^	deductible, 0%	deductible, 0% ^
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	deductible, 0%	deductible, 50%	deductible, 0%	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	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
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)*	deductible, 0%	Not Covered	deductible, 0%	Not Covered
Prescription Drugs				
Generic - Tier 1	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%
Specialty Prescription Drugs	deductible, 0%	deductible, 50%	deductible, 0%	deductible, 50%

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

PPO

Aggregate

HSA 3000g

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Medical Benefits		
Annual Vision Exam	deductible, 0%	deductible, 50%
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%	deductible, 50%
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, 0%	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 0%	deductible, 50%
Specialty Prescription Drugs	deductible, 0%	deductible, 50%

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

PPO Embedded

HSA 3000h

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $10,000 Family: $20,000
Medical Benefits		
Annual Vision Exam	deductible, 0%	deductible, 50%
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%	deductible, 50%
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, 0%	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 0%	deductible, 50%
Specialty Prescription Drugs	deductible, 0%	deductible, 50%

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

PPO Embedded

HSA 3000j

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Plan Year Out-of-Pocket Maximum	Single: $5,500 Family: $11,000	Single: $11,000 Family: $22,000
Medical Benefits		
Annual Vision Exam	deductible, 20%	deductible, 50%
Primary Care Provider Office Visits	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, 20%	deductible, 50%
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		
Generic - Tier 1	deductible, 20%	deductible, 50%
Brand - Tier 2	deductible, 20%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 20%	deductible, 50%
Specialty Prescription Drugs	deductible, 20%	deductible, 50%

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

PPO Embedded

HSA 5000h

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $15,000 Family: $30,000
Medical Benefits		
Annual Vision Exam	deductible, 0%	deductible, 50%
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%	deductible, 50%
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, 0%	Not Covered
Prescription Drugs		
Generic - Tier 1	deductible, 0%	deductible, 50%
Brand - Tier 2	deductible, 0%	deductible, 50%
Non-Participating Brand - Tier 3	deductible, 0%	deductible, 50%
Specialty Prescription Drugs	deductible, 0%	deductible, 50%

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

Section 2

Choose Your PPO Plan

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

- Traditional PPO plans
- Lower Participating out-of-pocket maximums
- Must pair with one of our pharmacy options (see Section 3)

The following apply to all medical plans listed in this section:

- Plans designated with "HRA" can be paired with a health reimbursement arrangement. If an HRA plan has an out-of-pocket maximum beyond the current Affordable Care Act limits, it must be paired with a health reimbursement arrangement.
- Your deductible and copayments/coinsurance, including for pharmacy coverage, all count toward your out-of-pocket maximum.
  - **Out-of-Pocket Maximum—**The most you'll pay out-of-pocket during your plan year. Once you reach this limit, Health Alliance pays 100 percent of covered expenses for the rest of the plan year.
  - **Deductible—**A set amount you pay before your plan starts helping pay for your medical care or pharmacy benefits. Some plans have separate medical and pharmacy deductibles.
  - **Copayment—**A set fee you pay when you use certain medical services covered by your plan.
  - **Coinsurance—**A percentage of the cost you pay when you use certain medical services covered by your plan.
- The PPO 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.

PPO
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Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $750 Family: $2,250	Single: $1,500 Family: $4,500	Single: $750 Family: $2,250	Single: $1,500 Family: $4,500
Plan Year Out-of-Pocket Maximum	Single: $3,500 Family: $7,750	Single: $7,000 Family: $15,500	Single: $3,500 Family: $7,750	Single: $7,000 Family: $15,500
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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, 10%	deductible, 50%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 10%	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*	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Routine Prenatal Care	deductible, 10%	deductible, 50%	deductible, 10%	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	deductible, 50%	$40	deductible, 50%
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. †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.

PPO
Embedded

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Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $750 Family: $2,250	Single: $1,500 Family: $4,500	Single: $750 Family: $2,250	Single: $1,500 Family: $4,500
Plan Year Out-of-Pocket Maximum	Single: $3,500 Family: $7,750	Single: $7,000 Family: $15,500	Single: $3,500 Family: $7,750	Single: $7,000 Family: $15,500
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 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*	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	deductible, 50%	$40	deductible, 50%
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. †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.

PPO Embedded

1000a | 1000c

Member Responsibility

	1000a Participating	1000a Non-Participating	1000c Participating	1000c Non-Participating
Plan Year Deductible	Single: $1,000 Family: $3,000	Single: $2,000 Family: $6,000	Single: $1,000 Family: $3,000	Single: $2,000 Family: $6,000
Plan Year Out-of-Pocket Maximum	Single: $4,500 Family: $12,000	Single: $14,000 Family: $32,000	Single: $4,500 Family: $12,000	Single: $14,000 Family: $32,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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, 10%	deductible, 50%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 10%	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*	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 10%	deductible, 50%	deductible, 10%	deductible, 50%
Routine Prenatal Care	deductible, 10%	deductible, 50%	deductible, 10%	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	deductible, 50%	$40	deductible, 50%
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. †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.

PPO
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Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $1,000 Family: $3,000	Single: $2,000 Family: $6,000	Single: $1,000 Family: $3,000	Single: $2,000 Family: $6,000
Plan Year Out-of-Pocket Maximum	Single: $4,500 Family: $12,000	Single: $14,000 Family: $32,000	Single: $4,500 Family: $12,000	Single: $14,000 Family: $32,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 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*	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	deductible, 50%	$40	deductible, 50%
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. †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.

PPO
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1500d

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $1,500 Family: $4,500	Single: $3,000 Family: $9,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $6,000	Single: $15,000 Family: $35,000
Member Benefits		
Annual Vision Exam	$40	deductible, 50%
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*	deductible, 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	$25	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, 20%	deductible, 50%
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	**See Pharmacy Options, Section 3**	

*Facility coverage only; provider 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.

PPO Embedded 2000c

Member Responsibility

	Participating	Non-Participating
Plan Year Deductible	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Medical Benefits		
Annual Vision Exam	deductible, 20%	deductible, 50%
Primary Care Provider Office Visits	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, 20%	deductible, 50%
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 deductible, 20%	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. †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.

PPO
Embedded

2500a

2500c

Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $2,500 Family: $7,500	Single: $5,000 Family: $15,000	Single: $2,500 Family: $7,500	Single: $5,000 Family: $15,000
Plan Year Out-of-Pocket Maximum	Single: $2,500 Family: $7,500	Single: $20,000 Family: $45,000	Single: $2,500 Family: $7,500	Single: $20,000 Family: $45,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	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*	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	deductilble, 50%	$40	deductible, 50%
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. †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.

PPO Embedded

	2500i		2500j	
	Member Responsibility			
	Participating	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $2,500 Family: $5,000	Single: $5,000 Family: $10,000	Single: $2,500 Family: $5,000	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: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Medical Benefits				
Annual Vision Exam	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Primary Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Specialty Care Provider Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Spinal Manipulations	deductible, 0%	deductible, 0% ^	deductible, 20%	deductible, 20% ^
Urgent Care Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
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, 50%	deductible, 20%	deductible, 50%
Inpatient Facility* *(including Maternity, Newborn** and Mental Health)*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Office Visits	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Mental Health/Substance Abuse Outpatient Facility Visits*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Physical Therapy, Occupational Therapy, Durable Medical Equipment	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Arm, Leg Prostheses and Custom Orthotics	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Diagnostic Testing *MRI/CT Scans, X-rays, Lab*	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
Routine Prenatal Care	deductible, 0%	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	deductible, 0%	deductible, 50%	deductible, 20%	deductible, 50%
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 deductible, 0%	Not Covered	first 3 visits $0, then deductible, 20%	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. 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.

PPO
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3000a 3000c

Member Responsibility

	3000a Participating	3000a Non-Participating	3000c Participating	3000c Non-Participating
Plan Year Deductible	Single: $3,000 Family: $9,000	Single: $6,000 Family: $18,000	Single: $3,000 Family: $9,000	Single: $6,000 Family: $18,000
Plan Year Out-of-Pocket Maximum	Single: $3,000 Family: $9,000	Single: $23,000 Family: $53,000	Single: $3,000 Family: $9,000	Single: $23,000 Family: $53,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 0%	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*	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	deductible, 50%	$40	deductible, 50%
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. †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.

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	4000d		4000f	
	Member Responsibility			
	Participating	**Non-Participating**	**Participating**	**Non-Participating**
Plan Year Deductible	Single: $4,000 Family: $12,000	Single: $10,000 Family: $30,000	Single: $4,000 Family: $12,000	Single: $10,000 Family: $30,000
Plan Year Out-of-Pocket Maximum	Single: $7,350 Family: $14,700	Single: $30,000 Family: $80,000	Single: $7,350 Family: $14,700	Single: $30,000 Family: $80,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 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*	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	deductible, 50%	$40	deductible, 50%
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. †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.

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Member Responsibility

	Participating	Non-Participating	Participating	Non-Participating
Plan Year Deductible	Single: $5,000 Family: $14,700	Single: $10,000 Family: $30,000	Single: $5,000 Family: $14,700	Single: $10,000 Family: $30,000
Plan Year Out-of-Pocket Maximum	Single: $5,000 Family: $14,700	Single: $30,000 Family: $80,000	Single: $5,000 Family: $14,700	Single: $30,000 Family: $80,000
Member Benefits				
Annual Vision Exam	$40	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health)*	deductible, 0%	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*	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	deductible, 50%	$40	deductible, 50%
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. †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.

PPO
Embedded

7350a 7350c

Member Responsibility

	7350a Participating	7350a Non-Participating	7350c Participating	7350c Non-Participating
Plan Year Deductible	Single: $7,350 Family: $14,700	Single: $15,000 Family: $45,000	Single: $7,350 Family: $14,700	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	deductible, 50%	$40	deductible, 50%
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%	$250 per procedure, then 20%	deductible, 50%
Inpatient Facility* (*Including Maternity, Newborn** and Mental Health*)	deductible, 0%	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*	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	deductible, 50%	$40	deductible, 50%
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. †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 3

Pair with a Pharmacy Option

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

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

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

Member Responsibility

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

Rx 1

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

Member Responsibility

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

Rx 2

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

Member Responsibility

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

Rx 3

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

Member Responsibility

Member Benefits	Participating	Non-Participating
Retail Drugs		
Generic - Tier 1	$20	50%
Brand - Tier 2	$40	50%
Non-Preferred Brand - Tier 3	$50	50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	20%	50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	20%	50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	20%	50%

Rx 8

Lifestyle/erectile dysfunction drug coverage is optional. This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to the Health Alliance Policy for detailed information regarding these plans. If pairing the medical product with an HSA, the medical deductible will apply before the pharmacy copayments. When applicable, Non-Participating 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	50%
Brand - Tier 2	$40	50%
Non-Preferred Brand - Tier 3	$80	50%
Preferred Specialty Pharmacy/Medical - Tier 4 *Preauthorization Required*	30%	50%
Non-Preferred Specialty Pharmacy/ Medical - Tier 5 *Preauthorization Required*	40%	50%
Non-Formulary Specialty Pharmacy/ Medical - Tier 6 *Preauthorization Required*	50%	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.

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - Qualified interpreters
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