



Health Alliance

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Health Alliance PPO Group Plan Description of Coverage Worksheet

Maximums/Deductibles/Limitations		Description of Coverage	
Preauthorization Deductible ** (applies if you fail to Preauthorize required services) Medical		Preferred Provider Not Applicable	Non-Preferred Provider 50% up to \$500
Plan Year Deductibles (Deductible applies unless otherwise specified. If Deductible applies, the Deductible must be met before benefits are paid by the Plan.) Medical Deductible		Preferred Provider Single: \$1,000 Family: \$2,000	Non-Preferred Provider Single: \$2,000 Family: \$4,000
Plan Year Out-of-Pocket Maximums (The maximum annual out-of-pocket expense includes Deductible expenses) Medical Specialty (including Infertility Specialty) Prescription Drugs		Preferred Provider Single: \$3,000 Family: \$6,000 Single: \$1,500 Family: \$4,500	Non-Preferred Provider Single: \$6,000 Family: \$12,000 Single: Unlimited Family: Unlimited
Plan Year Maximum Benefits Spinal Manipulation Outpatient (including Infertility) Prescription Drugs Specialty (including Infertility Specialty) Prescription Drugs		\$500 Combined Preferred and Non-Preferred Provider Unlimited Preferred Provider \$300,000 Preferred Provider	
Pre-Existing Condition Limitation**		50% (if applicable)	
Lifetime Maximum Benefits Overall Inpatient Mental Health Care and Substance Abuse Treatment Temporomandibular Joint (TMJ) Disorder		\$5,000,000 Combined Preferred and Non-Preferred Provider \$10,000 Combined Preferred and Non-Preferred Provider \$2,500 Combined Preferred and Non-Preferred Provider	
See Service/Benefit section for visit, day and unit limits			
	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
In the Hospital	Hospital Care (includes semi-private room and other Medically Necessary services)	20% Coinsurance	40% Coinsurance
Emergency Services	Emergency Services (Outpatient)	20% Coinsurance	Preferred Provider benefit applies

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Emergency Services	Emergency Ambulance Transportation. Ground ambulance for Emergency Medical Condition; air ambulance when cannot be safely transported by ground. Includes services received in or outside of the Service Area for an Emergency Medical Condition.	\$100 Copayment (Deductible does not apply)	Preferred Provider benefit applies
In the Doctor's Office <i>(Each Office Visit or Routine Physical Exam requires the Copayment or Coinsurance listed. In addition, other services obtained while in the office may require an additional Copayment or Coinsurance amount.)</i>	Office Visit – Primary Care	20% Coinsurance for office visit charge only (other services obtained while in the office may require an additional Copayment or Coinsurance amount).	40% Coinsurance
	Office Visit – Specialty Care	20% Coinsurance for office visit charge only (other services obtained while in the office may require an additional Copayment or Coinsurance amount).	40% Coinsurance
	Routine Physical Exams (Well child care, annual and school physicals)	20% Coinsurance	40% Coinsurance
	Immunizations (Preventive immunizations and inoculations for Wellness Care)	20% Coinsurance	40% Coinsurance
	Allergy Treatment and Testing	20% Coinsurance	40% Coinsurance
	Wellness Care (Includes mammograms, PAP smears, ovarian screening, prostate screening, colorectal screening, cholesterol screening, glaucoma and osteoporosis screening) <i>(If service is not provided in the Physician's office, it may be subject to the Outpatient Surgery Copayment, Coinsurance and/or Deductible. Refer to your Policy.)</i>	20% Coinsurance	40% Coinsurance
Medical Services	Diagnostic Tests and X-Rays	20% Coinsurance	40% Coinsurance
	Outpatient Surgery/Procedures (includes services performed in an Outpatient setting for which there is an associated facility fee)	20% Coinsurance	40% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Medical Services	Maternity Care		
	Hospital Care	20% Coinsurance	40% Coinsurance
	Routine Prenatal Care	20% Coinsurance	40% Coinsurance
	Newborn Care	20% Coinsurance (Newborn is subject to a separate Deductible and Coinsurance)	40% Coinsurance (Newborn is subject to a separate Deductible and Coinsurance)
	Infertility Services	Office Visit and Hospital	Office Visit and Hospital
	Diagnostic and treatment services	Copayments or Coinsurance apply	Copayments or Coinsurance apply
	Serious Mental Health Care		
	Outpatient 60 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 45 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Non-Serious Mental Health Care		
	Outpatient 20 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 10 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Substance Abuse Treatment		
	Outpatient 20 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 10 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Medical Services	Rehabilitation Services (speech, physical and occupational) Outpatient (includes home setting) Combined total of 60 visits per condition per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient (including Skilled Nursing) Combined total of 120 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
Other Services	Durable Medical Equipment, Orthopedic Appliances and Orthotics** <i>(a maximum benefit limit may apply)</i>	20% Coinsurance	50% Coinsurance
	Prosthetic Devices**	20% Coinsurance	50% Coinsurance
	Hospice Care	Office Visit and Hospital Care Copayments or Coinsurance apply	Office Visit and Hospital Care Copayments or Coinsurance apply
	Home Health Services Unlimited visits per Plan Year	20% Coinsurance	40% Coinsurance
	Vision Care**	20% Coinsurance	40% Coinsurance
	Spinal Manipulation**	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
	Human Organ Transplant	Office Visit and Hospital Care Copayments or Coinsurance apply. Transplants are covered when performed at a Health Alliance approved facility.	
	Temporomandibular Joint (TMJ) Disorder	Office Visit and Hospital Care Copayments or Coinsurance apply	Office Visit and Hospital Care Copayments or Coinsurance apply
Outpatient Prescription Drugs	Prescription Contraceptive Devices/Injectables**	20% Coinsurance	50% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Outpatient Prescription Drugs	Outpatient Prescription Drugs** For a 30 day supply, you pay:		
	Value Based	10% Coinsurance	50% Coinsurance
	Tier 1 Drugs	\$20 Copayment	50% Coinsurance
	Tier 2 Drugs	\$40 Copayment	50% Coinsurance
	Tier 3 Drugs	\$50 Copayment	50% Coinsurance
	Specialty Prescription Drugs**	20% Coinsurance	50% Coinsurance
	Infertility Outpatient Prescription Drugs** Limited to manufacturer's standard packaging		
	Tier 1 Drugs	\$20 Copayment	50% Coinsurance
	Tier 2 Drugs	\$40 Copayment	50% Coinsurance
	Tier 3 Drugs	\$50 Copayment	50% Coinsurance
	Infertility Specialty Prescription Drugs	20% Coinsurance	50% Coinsurance

* You also pay any charges in excess of the Usual, Customary and Reasonable (UCR) amount. Amounts over the UCR do not apply to the Out-of-Pocket Maximum.

** Copayments and Coinsurance payments for these services do not apply to the Medical Plan Year Out-of-Pocket Maximum.

Charges applied toward satisfying your Medical Deductible and Out-of-Pocket Maximum for Non-Preferred Providers are also applied to your Deductible and Out-of-Pocket Maximum for Preferred Providers. However, Preferred Provider charges do not apply toward your Non-Preferred Medical Deductible and Out-of-Pocket Maximum.

Members with Medicare Parts A and B as their primary coverage will not be subject to Health Alliance Copayments, Coinsurance or any applicable Medicare deductibles or coinsurance, except for prescription drugs (if applicable) for services received from Preferred Providers. For services received from Non-Preferred Providers, Members with Medicare Parts A and B as their primary coverage are responsible for Plan Copayments, Coinsurance and Out-of-Pocket Maximums prior to the Plan covering any applicable Medicare deductibles or coinsurance.

Service Area

To be eligible for enrollment in the Plan, you must live or work within the Service Area. Listed below are the counties within which Health Alliance Medical Plans, Inc., is authorized to offer the Health Alliance PPO Plan.

Adams, Alexander, Boone, Brown, Bureau, Carroll, Cass, Champaign, Christian, Clark, Clay, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Grundy, Gallatin, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Knox, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Marion, Madison, Marshall, Mason, Massac, McDonough, McLean, Menard, Mercer, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Washington, Warren, Wayne, White, Whiteside, Williamson, Winnebago, Woodford, Benton (Iowa), Boone (Iowa), Calhoun (Iowa), Carroll (Iowa), Clinton (Iowa), Dallas (Iowa), Delaware (Iowa), Greene (Iowa), Hamilton (Iowa), Hardin (Iowa), Jasper (Iowa), Johnson (Iowa), Lee (Iowa), Linn (Iowa), Marshall (Iowa), Polk (Iowa), Sac (Iowa), Scott (Iowa), Story (Iowa), Tama (Iowa), Warren (Iowa), Washington (Iowa), Webster (Iowa), Wright (Iowa)

This is a brief summary of Health Alliance group PPO benefits and exclusions, which are subject to change. Please refer to your Health Alliance Policy for detailed information regarding your Plan.