



## Health Alliance PPO Group Plan Description of Coverage Worksheet

Maximums/Deductibles/Limitations		Description of Coverage	
<b>Preauthorization Penalty **</b> (applies if you fail to Preauthorize required services) Medical		<b>Preferred Provider</b>  Not Applicable	<b>Non-Preferred Provider</b>  50% up to \$500 (whichever is less)
<b>Plan Year Deductible</b> (Deductible applies unless otherwise specified. If Deductible applies, the Deductible must be met before benefits are paid by the Plan.)***		<b>Preferred Provider</b> Single: \$2,500 Family: \$5,000	<b>Non-Preferred Provider</b> Single: \$5,000 Family: \$10,000
<b>Plan Year Out-of-Pocket Maximum</b> (The maximum annual out-of-pocket expense includes Deductible expenses)		<b>Preferred Provider</b> Single: \$2,500 Family: \$5,000	<b>Non-Preferred Provider</b> Single: \$10,000 Family: \$20,000
<b>Plan Year Maximum Benefits</b> Spinal Manipulation		\$500 Combined Preferred and Non-Preferred Provider	
Pre-Existing Condition Exclusion		0%	
<b>Lifetime Maximum Benefits</b> Overall Temporomandibular Joint (TMJ) Disorder		Unlimited Combined Preferred and Non-Preferred Provider \$2,500 Combined Preferred and Non-Preferred Provider	
<b>See Service/Benefit section for visit, day and unit limits</b>			
	<b>Service/Benefit</b>	<b>You Pay Preferred Provider</b>	<b>You Pay Non-Preferred Provider*</b>
<b>Hospital Services</b>	<b>Hospital Care</b> (includes observation bed stays, semi-private room and other Medically Necessary services)	0% Coinsurance	50% Coinsurance
<b>Emergency Services</b>	<b>Emergency Services (Outpatient)</b>	0% Coinsurance	Preferred Provider benefit applies
	<b>Emergency Ambulance Transportation.</b> 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.	0% Coinsurance	Preferred Provider benefit applies
<b>In the Doctor's Office</b>	<b>Office Visit – Primary Care</b>	0% Coinsurance	50% Coinsurance
	<b>Office Visit – Specialty Care</b>	0% Coinsurance	50% Coinsurance
	<b>Other services obtained while in the Doctor's Office, including Allergy Treatment and Testing or Wellness Care, may require an additional Copayment or Coinsurance amount</b>		
	<b>Annual Wellness Visit</b>	\$0 Copayment per visit (Deductible does not apply)	50% Coinsurance
	<b>Allergy Treatment and Testing</b>	0% Coinsurance	50% Coinsurance

	<b>Service/Benefit</b>	<b>You Pay Preferred Provider</b>	<b>You Pay Non-Preferred Provider*</b>
	<b>Wellness Care</b> <i>Refer to your Policy for the specific service under wellness care. Services not provided in the Physician's office may be subject to the Outpatient Surgery/Procedures Copayment, Coinsurance and/or Deductible.</i>	\$0 Copayment per service (Deductible does not apply)	50% Coinsurance
	<b>Breast Cancer Screening</b> Low-dose or digital mammography, comprehensive ultrasound breast screening	\$0 Copayment (Deductible does not apply)	50% Coinsurance
<b>Medical Services</b>	<b>Diagnostic Testing and X-Rays</b>	0% Coinsurance	50% Coinsurance
	<b>Outpatient Surgery/Procedures</b> <i>(Services performed in an Outpatient setting, including colonoscopy, when there is an associated facility fee)</i>	0% Coinsurance	50% Coinsurance
	<b>Maternity Care</b>		
	<b>Hospital Care</b>	0% Coinsurance	50% Coinsurance
	<b>Routine Prenatal Care</b>	0% Coinsurance	50% Coinsurance
	<b>Newborn Care</b> The first 48 hours of newborn inpatient care following a vaginal delivery or 96 hours of newborn inpatient care following a delivery by Caesarean section are covered under the mother's maternity coverage.	0% Coinsurance The properly enrolled newborn will be subject to a separate Hospital Care Copayment/Coinsurance and a separate Plan Year Medical Deductible.	50% Coinsurance The properly enrolled newborn will be subject to a separate Hospital Care Copay/Coinsurance and a separate Plan Year Medical Deductible.
	<b>Infertility Services</b> Diagnostic and treatment services	0% Coinsurance	50% Coinsurance
	<b>Serious Mental Health Care</b>		
	<b>Outpatient</b> Unlimited visits per Plan Year	0% Coinsurance	50% Coinsurance
	<b>Inpatient</b> Unlimited days per Plan Year	0% Coinsurance	50% Coinsurance
<b>Non-Serious Mental Health Care</b>			
<b>Outpatient</b> Unlimited visits per Plan Year	0% Coinsurance	50% Coinsurance	
<b>Inpatient</b> Unlimited days per Plan Year	0% Coinsurance	50% Coinsurance	
<b>Substance Abuse Treatment</b>			
<b>Outpatient</b> Unlimited visits per Plan Year	0% Coinsurance	50% Coinsurance	
<b>Inpatient</b> Unlimited days per Plan Year	0% Coinsurance	50% Coinsurance	

	<b>Service/Benefit</b>	<b>You Pay Preferred Provider</b>	<b>You Pay Non-Preferred Provider*</b>
<b>Medical Services</b>	<b>Rehabilitation Services (speech, physical and occupational)</b>  <b>Outpatient (includes home setting)</b> Combined total of 60 visits per condition per Plan Year combined Preferred and Non-Preferred Provider	0% Coinsurance	50% Coinsurance
	<b>Outpatient Speech Therapy for Pervasive Developmental Disorder (includes home setting)</b> Total of 20 additional visits per Plan Year	0% Coinsurance	50% Coinsurance
	<b>Inpatient (including Skilled Care)</b> Combined total of 120 days per Plan Year combined Preferred and Non-Preferred Provider	0% Coinsurance	50% Coinsurance
<b>Other Services</b>	<b>Durable Medical Equipment and Orthopedic Appliances</b> <i>( a maximum benefit limit may apply)</i>	0% Coinsurance	50% Coinsurance**
	<b>Prostheses</b> <i>( a maximum benefit limit may apply)</i>	0% Coinsurance	50% Coinsurance**
	<b>Hospice Care</b>	0% Coinsurance	50% Coinsurance
	<b>Home Health Services</b> Unlimited visits per Plan Year	0% Coinsurance	50% Coinsurance
	<b>Vision Care</b>	0% Coinsurance	50% Coinsurance**
	<b>Spinal Manipulation</b>	0% Coinsurance Preferred Provider Deductible Applies	
	<b>Human Organ Transplant</b>	0% Coinsurance Transplants are covered when performed at a Health Alliance approved facility	
	<b>Temporomandibular Joint (TMJ) Disorder</b>	0% Coinsurance	50% Coinsurance
<b>Outpatient Prescription Drugs</b>	<b>Prescription Contraceptive Devices/Injectables</b>	0% Coinsurance	50% Coinsurance**

	<b>Service/Benefit</b>	<b>You Pay Preferred Provider</b>	<b>You Pay Non-Preferred Provider*</b>
<b>Outpatient Prescription Drugs</b>	<b>Outpatient Prescription Drugs</b> For a 30 day supply:		
	<b>Value Based</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 1 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 2 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 3 Drugs</b>	0% Coinsurance (Deductible does not apply to smoking cessation drugs)	50% Coinsurance**
	<b>Specialty Prescription Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Infertility Outpatient Prescription Drugs</b> Limited to manufacturer's standard packaging		
	<b>Tier 1 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 2 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 3 Drugs</b>	0% Coinsurance	50% Coinsurance**
<b>Mail Order Prescription Drugs</b> For a 90 day supply:	<b>Infertility Specialty Prescription Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Value Based</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 1 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 2 Drugs</b>	0% Coinsurance	50% Coinsurance**
	<b>Tier 3 Drugs</b>	0% Coinsurance	50% Coinsurance**

\* You also pay any charges in excess of the Maximum Allowable charge. Amounts over the Maximum Allowable charge 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.

\*\*\* Single Deductible applies to Members on a single coverage plan. Family Deductible applies to Members on a plan that includes Dependent coverage. The entire Family Deductible must be satisfied before Plan coverage begins for any family Member.

### Service Area

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

Adams, Alexander, Boone, Brown, Bureau, Carroll, Cass, Champaign, Christian, Clark, Clay, Coles, Crawford, Cumberland, DeKalb, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Grundy, Gallatin, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Kendall, 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, and the Iowa counties: Benton, Blackhawk, Boone, Bremer, Butler, Calhoun, Carroll, Cedar, Clinton, Dallas, Delaware, Fayette, Greene, Grundy, Guthrie, Hamilton, Hardin, Humboldt, Jasper, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Madison, Marshall, Muscatine, Polk, Poweshiek, Sac, Scott, Story, Tama, Warren, Washington, Webster, Wright

*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.*