

01/01/2020

Member Responsibility

Member Benefits

In-Network

Out-of-Network

Plan Year Deductible

Includes Embedded Deductible. Members on this plan who meet their individual deductibles can use their coverage before the family deductible is met.

Single: \$3,100
Family: \$6,200

Single: Not Applicable
Family: Not Applicable

Plan Year Out-of-Pocket Maximum

Combined medical and pharmacy expenses including deductible, coinsurance amounts and copays.

Single: \$6,500
Family: \$13,000

Single: Not Applicable
Family: Not Applicable

Walk-in Patient Services

Annual Vision Exam
Primary Care Physician Office Visit
Specialty Care Physician Office Visit
Acupuncture
Spinal Manipulations
Urgent Care
Virtual Visits

\$20 per exam

\$20 per visit

\$40 per visit

\$20 per visit

\$40 per visit

\$40 per visit

\$0 visits 1-3, then \$20 copay

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

In Network Benefit Applies

Not Covered

Emergency Services

Emergency Department Visit

\$600 per visit and Deductible then 30%

In Network Benefit Applies

Emergency Ambulance Transportation

Deductible, 30%

In Network Benefit Applies

Hospital Services

*Outpatient Surgery/Procedures**

\$600 per procedure and Deductible then 30%

Not Covered

*Inpatient Facility**

\$800 per stay and Deductible then 30%

Not Covered

Mental Health/
Substance Abuse

Outpatient Office Visits

\$20 per visit

Not Covered

*Inpatient Facility**

\$800 per stay and Deductible then 30%

Not Covered

Rehabilitative And
Habilitative Services

Physical Therapy

Deductible, 30%

Not Covered

Occupational Therapy

Deductible, 30%

Not Covered

Durable Medical Equipment

Deductible, 30%

Not Covered

Diagnostic Services

MRI and CT Scans

\$600 per test and Deductible then 30%

Not Covered

Laboratory and X-rays

\$50 per test and Deductible then 30%

Not Covered

Routine Prenatal Care

Deductible, 30%

Not Covered

Maternity

Inpatient newborn covered on mother's policy up to 96 hours

*Inpatient Maternity Facility**

\$800 per stay and Deductible then 30%

Not Covered

*Inpatient Newborn Facility**

\$800 per stay and Deductible then 30%

Not Covered

Pediatric Services

Offered to children up to age 19

Pediatric Dental Exam

\$0 per exam

Not Covered

Pediatric Vision Exam

\$0 per exam

Not Covered

Pediatric Vision Materials

\$0 per item

Not Covered

Preventive & Wellness Services

Immunizations, adult and child annual physical exams, mammograms, PAP smears, cancer screenings and more. Age/frequency schedules apply.

\$0

Not Covered

Prescription Drugs Retail

Preferred Generic – Tier 1

\$0

Not Covered

Non-Preferred Generic – Tier 2

\$10

Not Covered

Preferred Brand – Tier 3

\$40

Not Covered

Non-Preferred Brand – Tier 4

\$80

Not Covered

Specialty

Preferred Specialty – Tier 5

50%

Not Covered

Pharmacy/Medical

Non-Preferred Specialty– Tier 6

50%

Not Covered

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

*Facility coverage only; physicians fees may apply



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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 316 Fifth Street, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-851-3379; telephone for members in Washington: 1-877-750-3515 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. IA, IL, IN, OH: Llame 1-800-851-3379, WA Llame: 1-877-750-3515 (TTY: 711).

注意: 如果你講中文, 語言協助服務, 免費的, 都可以給你。IA, IL, IN, OH: 呼叫 1-800-851-3379, WA: 呼叫 1-877-750-3515 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-851-3379, WA: Zadzwoń 1-877-750-3515 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-851-3379, WA: Gọi 1-877-750-3515 (TTY: 711).

주의: 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 IA, IL, IN, OH: 전화 WA: 1-877-750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-851-3379, WA: Вызов 1-877-750-3515 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-851-3379, WA: Tumawag 1-877-750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-851-3379، ولاية واشنطن: اتصل بالرقم: 1-877-750-3515 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistentendienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-851-3379, WA: Anruf 1-877-750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-851-3379, WA: Appelez 1-877-750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કોલ 1-800-851-3379, WA: કોલ 1-877-750-3515 (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 IA, IL, IN, OH: コール 1-877-750-3515 WA: コール (TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-851-3379, WA: Bel 1-877-750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-851-3379, WA: Виклик 1-877-750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-851-3379, WA: Chiamare 1-877-750-3515 (TTY: 711).