

# HEALTH ALLIANCE PLAN BENEFIT COMPARISON AHL REFORM GROUP PLANS (2-50) PPO / EPO

	High Option PPO/EPO Plan E		Mid-Level Option PPO/EPO Plan F		Mid-Level Option PPO/EPO Plan G		Standard Option PPO/EPO Plan L		HDHP Option PPO/EPO Plan H (HSA Compatible)		HDHP Option PPO/EPO Plan M (HSA Compatible)	
	IN- NETWORK	OUT-OF- NETWORK (PPO Only)	IN-NETWORK	OUT-OF- NETWORK (PPO Only)	IN-NETWORK	OUT-OF- NETWORK (PPO Only)	IN-NETWORK	OUT-OF- NETWORK (PPO Only)	IN-NETWORK	OUT-OF- NETWORK (PPO Only)	IN-NETWORK	OUT-OF- NETWORK (PPO Only)
<b>Benefit period</b>	calendar		calendar		calendar		calendar		calendar		calendar	
Annual Deductibles	\$0 Ind \$0 Family	\$500 Ind \$1000 Family	\$300 Ind \$600 Family	\$600 Ind \$1200 Family	\$500 Ind \$1000 Family	\$1000 Ind \$2000 Family	\$1000 Ind \$2000 Family	\$3000 Ind \$6000 Family	\$2500 Ind \$5000 Family		\$4000 Ind \$8000 Family	
Coinsurance maximums	\$0 Ind \$0 Family	\$3000 Ind \$6000 Family	\$2000 Ind \$4000 Family	\$4000 Ind \$8000 Family	\$3000 Ind \$6000 Family	\$6000 Ind \$12000 Family	\$2000 Ind \$4000 Family	\$5000 Ind \$10000 Family	see below	see below	see below	see below
Out-of-pocket maximum (includes deductible & coinsurance)	NA	NA	NA	NA	NA	NA	NA	NA	\$2500 Ind \$5000 Family	\$6000 Ind \$12000 Family	\$4000 Ind \$8000 Family	\$6000 Ind \$12000 Family
Lifetime maximum per covered individual (combined in- and out-of network)	\$5 million		\$5 million		\$5 million		\$5 million		\$5 million		\$5 million	
<b>Preventive</b>												
Office visit (Preventive)... Periodic physical exams, well baby/child exams, immunizations, routine eye and hearing exams	\$15 copay	Not covered	\$20 copay	Not covered	\$25 copay	Not covered	\$30 copay	Not covered	100%	Not covered	100%	Not covered
Immunizations, related lab tests & x-rays, pap smears & mammograms	100%	Not covered	100%	Not covered	100%	Not covered	100%	Not covered	100%	Not covered	100%	Not covered
<b>Outpatient Services</b>												
Office visit (Outpatient)	\$15 copay	Not covered	\$20 copay	Not covered	\$25 copay	Not covered	\$30 copay	Not covered	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Outpatient surgery and related services	100%	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Back Care, Eye exams & Audiometry exams	\$15 copay then 100%	70% after deductible	\$20 copay then 100%	70% after deductible	\$25 copay then 100%	60% after deductible	\$30 copay then 100%	60% after deductible	100% after deductible	70% after deductible	100% after deductible	70% after deductible
<b>Inpatient Services</b>												
Inpatient, Labor/Delivery, Mental Health, Chemical Dependency	100%	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	70% after deductible	100% after deductible	70% after deductible
<b>Emergency Services</b>												
Emergency care	\$75 copay	\$75 copay	\$75 copay	\$75 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Urgent care	\$30 copay	\$30 copay	\$40 copay	\$40 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	100% after deductible	70% after deductible	100% after deductible	70% after deductible
<b>Prescription Drugs</b>												
Rx options	\$10/\$20/\$40 \$10/\$30/\$50 \$10/\$40/\$40 \$10/\$60/\$60 \$15/\$60/50%** 50% coinsurance** No Rx		\$10/\$20/\$40 \$10/\$30/\$50 \$10/\$40/\$40 \$10/\$60/\$60 \$15/\$60/50%** 50% coinsurance** No Rx		\$10/\$20/\$40 \$10/\$30/\$50 \$10/\$40/\$40 \$10/\$60/\$60 \$15/\$60/50%** 50% coinsurance** No Rx		\$10/\$20/\$40 \$10/\$30/\$50 \$10/\$40/\$40 \$10/\$60/\$60 \$15/\$60/50%** 50% coinsurance** No Rx		100% after deductible		100% after deductible	

\*\* Rx options: 50% coinsurance (\$10 min/\$100 max per fill)

10/29/2008

**NOTE: The above comparisons are to be used for general reference only. Please refer to individual benefit summaries for benefit levels for each service**