Health Alliance™

POS 3000 Rx644 NS2

			Member Responsibility	
Member Benefits			**In-Network**	**Out-of-Network (OON)**
Plan Year Deductible	**Medical**	Individual	$3,000	$7,500
Embedded		Family	$9,000	$22,500
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical & pharmacy expenses including deductible, coinsurance & copayments will not exceed the IRS maximum allowed.	**Medical**	Individual	$6,000	$30,000
		Family	$17,100	$60,000
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per primary medical diagnosis per plan year combined PT/OT/ST combined in-net and OON	
Habilitative Services			60 visits per primary medical diagnosis per plan year combined PT/OT/ST combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Home Health			Unlimited	
Chiropractic Services (includes muscle manipulations)			$500 maximum per plan year combined in-net and OON	
Temporomandibular Joint (TMJ) Treament			$2,500 maximum per plan year	
Vision Exam			Once every 12 months	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$40 per exam	Not Covered
Primary Care Physician Office Visits			*$30 per visit^	40%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$50 per visit^	40%
Chiropractic Services			*50%	In Network Benefit Applies
Acupuncture			*$30 per visit	In Network Benefit Applies
Urgent Care Visits			*$50 per visit^	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			20%	40%
Emergency Services				
Emergency Department Visits			*$275 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			$100, then 20% per transport	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			20%	40%
Outpatient Surgery/Procedures Physician/Surgeon Services			20%	40%
Inpatient Hospitalization Facility Fees			20%	40%
Inpatient Physician/Surgeon Fees			20%	40%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services			20%	40%
Inpatient Rehabilitation/Skilled Nursing Facility			20%	40%
Home Health			20%	40%
Diagnostic Services				
MRI and CT Scans			20%	40%
Diagnostic Testing			20%	40%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$30 per visit^	40%
Inpatient Services			20%	40%
Virtual Mental Health Visits			*$0 per visit	Not Covered

Member Benefits	In-Network	Out-of-Network (OON)
Prescription Drugs		
30 day supply		
Generic - Tier 1	*$10	50%
Brand - Tier 2	*$40	50%
Non-Preferred Brand - Tier 3	*$80	50%
Preferred Specialty Pharmacy/Medical - Tier 4	*$100	50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	*$100	50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	*$100	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	20%	40%
Maternity Inpatient	20%	40%
Newborn Care	20%	40%
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	40%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	20%	40%
Abortion Procedure Facility Fee	20%	40%
Abortion Procedure Physician Fee	20%	40%
Durable Medical Equipment	20%	40%

* Deductible does not apply

^ Additional, other services obtained while in the office may require an additional copayment or coinsurance.

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, 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.

This is a brief statement of Health Alliance **POS** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **POS** Policy booklet for more detail about your health plan. This document is in conjunction with the Summary of Benefits and Coverage (SBC). You can view your SBC online at www.healthalliance.org or request a copy by contacting the customer service number on the back of your ID card.