Health Alliance™

**POS 2500B 19 Rx231**

| | | | Member Responsibility | |
|---|---|---|---|---|
| **Member Benefits** | | | **In-Network** | **Out-of-Network (OON)** |
| **Plan Year Deductible** | **Medical** | Individual | $2,500 | $5,000 |
| **Embedded** | | Family | $5,000 | $10,000 |
| | **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 | $5,000 | $10,000 |
| | | Family | $10,000 | $20,000 |
| **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 |
| Virtual Visits | | | *$0 per visits 1-3, then $25 visits 4-unlimited^ | Not Covered |
| Primary Care Physician Office Visits | | | *$25 per visit^ | 40% |
| Specialty Care Physician Office Visits | | | *$40 per visit^ | 40% |
| Chiropractic Services | | | *50% | In Network Benefit Applies |
| Acupuncture | | | *$25 per visit | In Network Benefit Applies |
| Urgent Care Visits | | | *$50 per visit^ | 40% |
| Allergy Treatment and Testing | | | 20% | 40% |
| **Emergency Services** | | | | |
| Emergency Department Visits | | | *$250 per visit | In Network Benefit Applies |
| Emergency Ambulance Transportation | | | *$100 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 | | | *$25 per visit^ | 40% |
| Inpatient Services | | | 20% | 40% |

| Member Benefits | In-Network | Out-of-Network (OON) |
|---|---|---|
| **Prescription Drugs** | | |
| *30 day supply* | | |
| Preferred Generic - Tier 1 | *$0 | 50% |
| Non-Preferred Generic - Tier 2 | *$10 | 50% |
| Preferred Brand - Tier 3 | *$40 | 50% |
| Non-Preferred Brand - Tier 4 | *$80 | 50% |
| Preferred Specialty - Tier 5 | *30% | 50% |
| Non-Preferred Specialty - Tier 6 | *50% | 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 exams & 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.