



2021 POS 1000 Elite Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
<b>Plan Year Deductible Embedded</b>	<b>Medical</b>	Individual	\$1,000	\$2,000
		Family	\$2,000	\$4,000
	<b>Pharmacy</b>	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	\$120	Not Applicable
<b>Plan Year Out-of-Pocket Maximum (OOPM)</b>				
<i>Combined medical and pharmacy expenses including deductible, coinsurance &amp; copayments.</i>	<b>Medical/Pharmacy</b>	Individual	\$7,000	\$14,500
		Family	\$14,000	\$29,000
<i>Dental OOPM goes toward medical OOPM</i>	<b>Pediatric Dental</b>	Individual	\$350	Not Applicable
		Family	\$700	Not Applicable
<b>Contract Year Maximum Benefits</b>				
	Cardiac Rehabilitation Services		36 OP sessions w/in 6 month of event combined in-net and OON	
	Outpatient Rehabilitation Services		60 visits per condition per plan year combined in-net and OON	
	Habilitative Services		60 visits per condition per plan year combined in-net and OON	
	Chiropractic Services		25 visits per plan year combined in-net and OON	
	Adult Vision Exam		Once every 12 months.	
	Acupuncture Treatment		15 visits per plan year combined in-net and OON	
	Pediatric Vision Exam		Once every 12 months combined in-net and OON	
	Pediatric Vision Materials		Once every 12 months combined in-net and OON	
	Pediatric Dental Exam		Once every 6 months combined in-net and OON	
<b>Ambulatory Patient Services</b>				
	Vision Exam		*\$20 per exam	Not Covered
	Virtual Visits		*\$0 visits 1-3, then \$20 copay	Not Covered
	Primary Care Physician Office Visits		*\$20 per visit	50%
	Specialty Care Physician Office Visits		*\$50 per visit	50%
	Chiropractic Services		*\$50 per visit	In Network Benefit Applies
	Acupuncture		*\$20 per visit	In Network Benefit Applies
	Urgent Care Visits		*\$50 per visit	In Network Benefit Applies
	Allergy Treatment and Testing		30%	50%
<b>Emergency Services</b>				
	Emergency Department Visits		*\$1,500 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		30%	In Network Benefit Applies
<b>Hospital Services</b>				
	Outpatient Surgery/Procedures Facility Fee		30%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		*\$1,500 per procedure	50%
	Inpatient Hospitalization Facility Fees		^\$1,500 per stay and Deductible then 30%	50%
	Inpatient Physician/Surgeon Fees		30%	50%
<b>Rehabilitative and Habilitative Services</b>				
	Outpatient Rehabilitation Services (PT, OT, ST)		30%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		30%	50%
	Home Health		30%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
<b>Diagnostic Services</b>		
MRI and CT Scans	30%	50%
Laboratory and X-rays	*\$500	50%
<b>Mental Health/Substance Use Treatment</b>		
Outpatient Office Visits	*\$20 per visit	50%
Inpatient Services	^\$1,500 per stay and Deductible then 30%	50%
<b>Prescription Drugs</b>		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$10	50%
Tier 3 - Preferred Brand	*\$40	50%
Tier 4 - Non-Preferred Brand	*\$80	50%
Tier 5 - Preferred Specialty	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
<b>Maternity</b>		
<i>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.</i>		
Routine Prenatal Care	30%	50%
Maternity Inpatient	^\$1,500 per stay and Deductible then 30%	50%
Newborn Care	^\$1,500 per stay and Deductible then 30%	50%
<b>Pediatric Services</b>		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	*\$0 per exam	Not Covered
Preventive Dental Services	*\$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
<b>Preventive and Wellness Services</b>		
<i>Immunizations, adult &amp; child annual physical exams, mammograms, PAP smears, prostate exams &amp; more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
<b>Other Services</b>		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	30%	50%
Abortion Procedure Facility Fee	30%	50%
Abortion Procedure Physician Fee	30%	50%
Durable Medical Equipment	30%	50%

\* Deductible does not apply

^ Copay applies before the Deductible

**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](http://www.healthalliance.org) or request a copy by contacting the customer service number on the back of your ID card.