



2021 POS 8000 Elite Bronze

| Member Benefits   | Member Responsibility              |  |   |  |
|---|------------------------------------|--|---|--|
|   |                                    |  | Participating (In-Network)                                    | Non-Participating (Out-of-Network (OON)) |
| <b>Plan Year Deductible Embedded</b>  | <b>Medical</b>                     | Individual   | \$8,000   | \$16,000                                 |
|   |                                    | Family   | \$16,000  | \$32,000                                 |
|   | <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   | \$8,500   | \$28,500                                 |
|   |                                    | Family   | \$17,000  | \$57,000                                 |
| <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  | 50%   | Not Covered                              |
|   |                                    | Virtual Visits   | ^\$0 visits 1-3, then Deductible and 50%                      | Not Covered                              |
|   |                                    | Primary Care Physician Office Visits                     | 50%   | 50%                                      |
|   |                                    | Specialty Care Physician Office Visits                   | 50%   | 50%                                      |
|   |                                    | Chiropractic Services                                    | 50%   | In Network Benefit Applies               |
|   |                                    | Acupuncture  | 50%   | In Network Benefit Applies               |
|   |                                    | Urgent Care Visits                                       | 50%   | In Network Benefit Applies               |
|   |                                    | Allergy Treatment and Testing                            | 50%   | 50%                                      |
| <b>Emergency Services</b>   |                                    |  |   |  |
|   |                                    | Emergency Department Visits                              | 50%   | In Network Benefit Applies               |
|   |                                    | Emergency Ambulance Transportation                       | 50%   | In Network Benefit Applies               |
| <b>Hospital Services</b>  |                                    |  |   |  |
|   |                                    | Outpatient Surgery/Procedures Facility Fee               | 50%   | 50%                                      |
|   |                                    | Outpatient Surgery/Procedures Physician/Surgeon Services | 50%   | 50%                                      |
|   |                                    | Inpatient Hospitalization Facility Fees                  | 50%   | 50%                                      |
|   |                                    | Inpatient Physician/Surgeon Fees                         | 50%   | 50%                                      |
| <b>Rehabilitative and Habilitative Services</b>   |                                    |  |   |  |
|   |                                    | Outpatient Rehabilitation Services (PT, OT, ST)          | 50%   | 50%                                      |
|   |                                    | Inpatient Rehabilitation/Skilled Nursing Facility        | 50%   | 50%                                      |
|   |                                    | Home Health  | 50%   | 50%                                      |

| Member Benefits   | Participating (In-Network) | Non-Participating (Out-of-Network (OON)) |
|---|----------------------------|--|
| <b>Diagnostic Services</b>  |                            |  |
| MRI and CT Scans  | 50%                        | 50%                                      |
| Laboratory and X-rays   | 50%                        | 50%                                      |
| <b>Mental Health/Substance Use Treatment</b>  |                            |  |
| Outpatient Office Visits  | 50%                        | 50%                                      |
| Inpatient Services  | 50%                        | 50%                                      |
| <b>Prescription Drugs</b>   |                            |  |
| <i>30 day supply</i>  |                            |  |
| Tier 1 - Preferred Generic  | 50%                        | 50%                                      |
| Tier 2 - Non-Preferred Generic  | 50%                        | 50%                                      |
| Tier 3 - Preferred Brand  | 50%                        | 50%                                      |
| Tier 4 - Non-Preferred Brand  | 50%                        | 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   | 50%                        | 50%                                      |
| Maternity Inpatient   | 50%                        | 50%                                      |
| Newborn Care  | 50%                        | 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  | 50%                        | 50%                                      |
| Abortion Procedure Facility Fee   | 50%                        | 50%                                      |
| Abortion Procedure Physician Fee  | 50%                        | 50%                                      |
| Durable Medical Equipment   | 50%                        | 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.