Health Alliance℠

2021 POS HSA 6900 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$6,900	$13,800
Embedded		Family	$13,800	$27,600
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,900	$26,300
		Family	$13,800	$52,600
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
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 condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Chiropractic Services			25 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	
Ambulatory Patient Services				
Vision Exam			0%	Not Covered
Virtual Visits			0%	Not Covered
Primary Care Physician Office Visits			0%	50%
Specialty Care Physician Office Visits			0%	50%
Chiropractic Services			0%	In Network Benefit Applies
Acupuncture			0%	In Network Benefit Applies
Urgent Care Visits			0%	In Network Benefit Applies
Allergy Treatment and Testing			0%	50%
Emergency Services				
Emergency Department Visits			0%	In Network Benefit Applies
Emergency Ambulance Transportation			0%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			0%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			0%	50%
Inpatient Hospitalization Facility Fees			0%	50%
Inpatient Physician/Surgeon Fees			0%	50%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			0%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			0%	50%
Home Health			0%	50%
Diagnostic Services				
MRI and CT Scans			0%	50%
Laboratory and X-rays			0%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	0%	50%
Inpatient Services	0%	50%
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	0%	50%
Tier 2 - Non-Preferred Generic	0%	50%
Tier 3 - Preferred Brand	0%	50%
Tier 4 - Non-Preferred Brand	0%	50%
Tier 5 - Preferred Specialty	0%	50%
Tier 6 - Non-Preferred Specialty	0%	50%
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	0%	50%
Maternity Inpatient	0%	50%
Newborn Care	0%	50%
Pediatric Services		
(members up to the age of 19 years old)		
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
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	50%
Abortion Procedure Facility Fee	0%	50%
Abortion Procedure Physician Fee	0%	50%
Durable Medical Equipment	0%	50%

* Deductible does not apply

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.