Health Alliance™

Local Government Health Plan

			Member Responsibility	
Member Benefits			**In-Network**	**Out-of-Network (OON)**
Plan Year Deductible	**Medical**	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Pharmacy	Individual	$175	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	$3,000	Not Applicable
		Family	$6,000	Not Applicable
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event	
Outpatient Rehabilitation Services			60 visits per primary medical diagnosis per plan year combined PT/OT/ST	
Habilitative Services			60 visits per primary medical diagnosis per plan year combined PT/OT/ST	
Acupuncture Treatment			15 visits per plan year	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			Not Covered	Not Covered
Virtual Visits			$10 per visit	Not Covered
Primary Care Physician Office Visits			$40 per visit	Not Covered
Specialty Care Physician Office Visits			$45 per visit	Not Covered
Chiropractic Services			$45 per visit	Not Covered
Acupuncture			$40 per visit	Not Covered
Urgent Care Visits			$40 per visit	$40 per visit
Allergy Treatment and Testing			$0 per visit	Not Covered
Emergency Services				
Emergency Department Visits			$300 per visit	$300 per visit
Emergency Ambulance Transportation			$0 per transport	$0 per transport
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			$300 per procedure	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			0%	Not Covered
Inpatient Hospitalization Facility Fees			$350 per stay	Not Covered
Inpatient Physician/Surgeon Fees			0%	Not Covered
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services			$40 per visit	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			$0 per stay	Not Covered
Home Health			$45 per visit	Not Covered
Diagnostic Services				
MRI and CT Scans			$0 per service	Not Covered
Diagnostic Testing Laboratory			$0 per service	Not Covered
Diagnostic Testing X-Ray			$0 per service	Not Covered
Mental Health/Substance Use Treatment				
Outpatient Office Visits			$40 per visit	Not Covered
Inpatient Services			$350 per stay	Not Covered
Prescription Drugs				
30 day supply				
Reduced Generic Tier 1			$4	Not Covered
Generic Tier 1			$15	Not Covered
Preferred Brand Tier 2			$30	Not Covered
Non-Preferred Brand Tier 3			$60	Not Covered
Specialty Tier 4			$120	Not Covered

Member Benefits	In-Network	Out-of-Network (OON)
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	$50	Not Covered
Maternity Inpatient	$350 per stay	Not Covered
Newborn Care	$350 per stay	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	Not Covered
Abortion Procedure Facility Fee	$300 per procedure	Not Covered
Abortion Procedure Physician Fee	0%	Not Covered
Durable Medical Equipment	30%	Not Covered

This is a brief statement of Health Alliance **HMO** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **HMO** 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.