



2023 HMO 9100 Elite Catastrophic

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
<b>Plan Year Deductible Embedded</b>	<b>Medical</b>	Individual	\$9,100	Not Applicable
		Family	\$18,200	Not Applicable
	<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	\$9,100	Not Applicable
		Family	\$18,200	Not Applicable
<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	
	Outpatient Rehabilitation Services		60 visits per condition per plan year	
	Habilitative Services		60 visits per condition per plan year	
	Chiropractic Services		25 visits per plan year.	
	Adult Vision Exam		Once every 12 months	
	Acupuncture Treatment		15 visits per plan year	
	Pediatric Vision Exam		Once every 12 months	
	Pediatric Vision Materials		Once every 12 months.	
	Pediatric Dental Exam		Once every 6 months.	
	Pediatric Vision Therapy		12 visits for treatment of Convergence Insufficiency per plan year	
<b>Ambulatory Patient Services</b>				
	Vision Exam	0%		Not Covered
	Virtual Visits	^\$0 visits 1-3, then Deductible and 0%		Not Covered
	Primary Care Physician Office Visits	^\$0 visits 1-3, then Deductible and 0%		Not Covered
	Specialty Care Physician Office Visits	0%		Not Covered
	Chiropractic Services	0%		Not Covered
	Acupuncture	^\$0 visits 1-3, then Deductible and 0%		Not Covered
	Urgent Care Visits	0%		In Network Benefit Applies
	Allergy Treatment and Testing	0%		Not Covered
<b>Emergency Services</b>				
	Emergency Department Visits	0%		In Network Benefit Applies
	Emergency Ambulance Transportation	0%		In Network Benefit Applies
<b>Hospital Services</b>				
	Outpatient Surgery/Procedures Facility Fee	0%		Not Covered
	Outpatient Surgery/Procedures Physician/Surgeon Services	0%		Not Covered
	Inpatient Hospitalization Facility Fees	0%		Not Covered
	Inpatient Physician/Surgeon Fees	0%		Not Covered
<b>Rehabilitative and Habilitative Services</b>				
	Outpatient Rehabilitation Services (PT, OT, ST)	0%		Not Covered
	Inpatient Rehabilitation/Skilled Nursing Facility	0%		Not Covered
	Home Health	0%		Not Covered
<b>Diagnostic Services</b>				
	MRI and CT Scans	0%		Not Covered
	Laboratory and X-rays	0%		Not Covered
<b>Mental Health/Substance Use Treatment</b>				
	Outpatient Office Visits	\$0 visits 1-3, then Deductible and 0%		Not Covered
	Inpatient Services	0%		Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
<b>Prescription Drugs</b>		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	0%	Not Covered
Tier 2 - Non-Preferred Generic	0%	Not Covered
Tier 3 - Preferred Brand	0%	Not Covered
Tier 4 - Non-Preferred Brand	0%	Not Covered
Tier 5 - Preferred Specialty	0%	Not Covered
Tier 6 - Non-Preferred Specialty	0%	Not Covered

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 and Out-of-Pocket Maximum. 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	0%	Not Covered
Maternity Inpatient	0%	Not Covered
Newborn Care	0%	Not Covered

### 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	0%	Not Covered
Major Dental Services	0%	Not Covered
Medically Necessary Orthodontia Services	0%	Not Covered
Pediatric Vision Exam	*\$0 per exam	Not Covered
Pediatric Vision Materials	*\$0 per item	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
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### 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	0%	Not Covered
Abortion Procedure Physician Fee	0%	Not Covered
Durable Medical Equipment	0%	Not Covered

^ Copay applies before the Deductible

\* 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.

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