



2023 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	
	Acupuncture Treatment		15 visits 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.	
	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	
	Pediatric Vision Therapy		12 visits for treatment of Convergence Insufficiency per plan year	
<b>Ambulatory Patient Services</b>				
	Vision Exam	50%	Not Covered	
	Virtual Visits	*\$0 visits 1-3, then \$65 per visit	Not Covered	
	Primary Care Physician Office Visits	*\$65 per visit	50%	
	Specialty Care Physician Office Visits	*\$105 per visit	50%	
	Chiropractic Services	*\$105 per visit	In Network Benefit Applies	
	Acupuncture	*\$65 per visit	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%	
<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	*\$65 per visit	50%	
	Inpatient Services	50%	50%	

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
<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%

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	50%	50%
Maternity Inpatient	50%	50%
Newborn Care	50%	50%

### Pediatric Services

*(members up to the age of 19 years old)*

Pediatric Dental Exam	*\$0	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%
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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	50%	50%
Abortion Procedure Facility Fee	50%	50%
Abortion Procedure Physician Fee	50%	50%
Durable Medical Equipment	50%	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](http://www.healthalliance.org) or request a copy by contacting the customer service number on the back of your ID card.