Health Alliance™

2023 POS 8000 Elite Bronze Ind CSR

			Member Responsibility		
Member Benefits			**Participating (In-Network Tier 1)**	**Participating (In-Network Tier 2)**	**Non-Participating (Out-of-Network (OON) Tier 3)**
Plan Year Deductible	**Medical**	Individual	$0	$8,000	$16,000
Embedded		Family	$0	$16,000	$32,000
	Pharmacy	Individual	$0	Not Applicable	Not Applicable
		Family	$0	Not Applicable	Not Applicable
	Dental Per Member		$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$8,500	$28,500
		Family	$0	$17,000	$57,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$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		
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		
Ambulatory Patient Services					
Vision Exam			$0 per exam	50%	Not Covered
Virtual Visits			$0 per visit	*$0 visits 1-3, then $65 per visit	Not Covered
Primary Care Physician Office Visits			$0 per visit	*$65 per visit	50%
Specialty Care Physician Office Visits			$0 per visit	*$105 per visit	50%
Chiropractic Services			$0 per visit	*$105 per visit	$105 per visit
Acupuncture			$0 per visit	*$65 per visit	*$65 per visit
Urgent Care Visits			$0 per visit	50%	50%
Allergy Treatment and Testing			$0	50%	50%
Emergency Services					
Emergency Department Visits			$0 per visit	50%	50%
Emergency Ambulance Transportation			$0	50%	50%
Hospital Services					
Outpatient Surgery/Procedures Facility Fee			$0	50%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			$0	50%	50%
Inpatient Hospitalization Facility Fees			$0 per stay	50%	50%
Inpatient Physician/Surgeon Fees			$0	50%	50%
Rehabilitative and Habilitative Services					
Outpatient Rehabilitation Services (PT, OT, ST)			$0 per visit	50%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			$0 per stay	50%	50%
Home Health			$0	50%	50%
Diagnostic Services					
MRI and CT Scans			$0 per test	50%	50%
Laboratory and X-rays			$0 per test	50%	50%

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	*$65 per visit	50%
Inpatient Services	$0 per stay	50%	50%
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic	$0	50%	50%
Tier 2 - Non-Preferred Generic	$0	50%	50%
Tier 3 - Preferred Brand	$0	50%	50%
Tier 4 - Non-Preferred Brand	$0	50%	50%
Tier 5 - Preferred Specialty	$0	50%	50%
Tier 6 - Non-Preferred Specialty	$0	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	$0	50%	50%
Maternity Inpatient	$0 per stay	50%	50%
Newborn Care	$0 per stay	50%	50%
Pediatric Services			
(members up to the age of 19 years old)			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$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	*$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%	50%
Abortion Procedure Facility Fee	$0	50%	50%
Abortion Procedure Physician Fee	$0	50%	50%
Durable Medical Equipment	$0	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 or request a copy by contacting the customer service number on the back of your ID card.