LGHP FY19

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Pharmacy	Individual	$150	Not Applicable
		Family	$300	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	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 condition per plan year	
		Home Health	Unlimited with Pre-authorization	
Ambulatory Patient Services				
		Vision Exam	Not Covered	Not Covered
		Virtual Visits	$35 per visit	Not Covered
		Primary Care Physician Office Visits	$35 per visit	Not Covered
		Specialty Care Physician Office Visits	$35 per visit	Not Covered
		Spinal Manipulations	$35 per visit	Not Covered
		Urgent Care Visits	$35 per visit	Not Covered
		Allergy Treatment and Testing	$0	Not Covered
Emergency Services				
		Emergency Department Visits	$250 per visit	$250 per visit
		Emergency Ambulance Transportation	$0	$0
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	$250 per procedure	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	0%	Not Covered
		Inpatient Hospitalization Facility Fees	$300 per stay	Not Covered
		Inpatient Physician/Surgeon Fees	0%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services	$35 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	Not Covered
		Home Health	$35 per visit	Not Covered
Diagnostic Services				
		MRI and CT Scans	$0 per service	Not Covered
		Diagnostic Testing	$0 per service	Not Covered
Mental Health/Substance Use Treatment				
		Outpatient Office Visits	$35 per visit	Not Covered
		Inpatient Services	$300 per stay	Not Covered
Prescription Drugs *30 day supply*				
		Generic - Tier 1	$13.50	Not Covered
		Brand - Tier 2	$27	Not Covered
		Non-Preferred Brand - Tier 3	$54	Not Covered
		Preferred Specialty Pharmacy/Medical - Tier 4	$108	Not Covered
		Non-Preferred Specialty Pharmacy/Medical - Tier 5	$108	Not Covered
		Non-Formulary Specialty Pharmacy/Medical - Tier 6	$108	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	$300 per stay	Not Covered
Newborn Care	$300 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
Durable Medical Equipment	25%	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.