Health Alliance

PPO 2500c Rx8

			Member Responsibility	
Member Benefits			**Preferred (In-Network)**	**Non-Preferred (Out-of-Network (OON))**
Plan Year Deductible	**Medical**	Individual	$2,500	$5,000
Embedded		Family	$7,500	$15,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,500	$20,000
		Family	$7,500	$45,000
Contract Year Maximum Benefits				
Cardiac Rehabilitation			36 OP session 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	
Inpatient Rehabilitation Services/Skilled Nursing Facility			120 per plan year combined in-net and OON	
Home Health			Unlimited with Pre-authorization	
Spinal Manipulations (includes muscle manipulations)			$500 maximum per plan year combined in-net and OON	
Temporomandibular Joint (TMJ) Treament			$2,500 maximum per plan year	
Vision Exam			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$40 per exam	50%
Primary Care Physician Office Visits			*$40 per visit^	50%
Specialty Care Physician Office Visits			*$65 per visit^	50%
Spinal Manipulations			*50%	*50%
Urgent Care Visits			*$80 per visit^	50%
Allergy Treatment and Testing			0%	50%
Emergency Services				
Emergency Department Visits			*$250 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			*$150	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			*$250 then 20% per procedure	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			20%	50%
Inpatient Hospitalization Facility Fees			*$500 then 20% per stay	50%
Inpatient Physician/Surgeon Fees			20%	50%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services			0%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			0%	50%
Home Health			0%	50%
Diagnostic Services				
MRI and CT Scans			0%	50%
Diagnostic Testing			0%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$40 per visit^	50%
Inpatient Services			*$500 then 20% per stay	50%
Non-Serious Mental Health Care			See in network outpatient office visit or inpatient services benefit.	50%

Member Benefits	Preferred (In-Network)	Non-Preferred (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
Generic - Tier 1	*$20	50%
Brand - Tier 2	*$40	50%
Non-Preferred Brand - Tier 3	*$50	50%
Preferred Specialty Pharmacy/Medical - Tier 4	*20%	50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	*20%	50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	*20%	50%
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%
Maternity Inpatient	*$500 then 20% per stay	50%
Newborn Care	*$500 then 20% per stay	50%
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screening & more. Age/frequency schedules apply.		
Wellness Care	*$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%
Durable Medical Equipment	0%	50%

* Deductible does not apply

^ Additional, other services obtained while in the office may require an additional copayment or coinsurance.

Embedded deductible definition - if there are two or more people on this plan – meaning the family amount(s) apply – you have a separate individual deductible within (or embedded within) the family deductible. This gives each member on the plan 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 **PPO** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **PPO** 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.