



Simplete Memorial HMO 100 Platinum

			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 Embedded	Medical	Individual	\$100	\$300	Not Applicable
		Family	\$200	\$600	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
	Dental Per Member		Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	Medical/Pharmacy	Individual	\$2,000	\$3,000	Not Applicable
		Family	\$4,000	\$6,000	Not Applicable
Dental OOPM goes toward medical OOPM	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Applicable
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials	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		
Habilitative Services			60 visits per condition per plan year		
Spinal Manipulations (includes muscle manipulations)			25 visits per plan year.		
Adult Vision Exam			Once every 12 months.		
Pediatric Vision Exam			Once every 12 months.		
Pediatric Vision Materials			Once every 12 months.		
Ambulatory Patient Services					
Vision Exam			*\$20 per exam	*\$20 per exam	Not Covered
Virtual Visits			*\$0 per visit	*\$0 per visit	Not Covered
Primary Care Physician Office Visits			*\$0 per visit	*\$20 per visit	Not Covered
Specialty Care Physician Office Visits			*\$30 per visit	*\$30 per visit	Not Covered
Spinal Manipulations			*\$30 per visit	*\$30 per visit	Not Covered
Urgent Care Visits			*\$30 per visit	*\$50 per visit	In Network Benefit Applies
Allergy Treatment and Testing			5%	15%	Not Covered
Emergency Services					
Emergency Department Visits			*\$300 per visit	*\$300 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			5%	5%	In Network Benefit Applies
Hospital Services					
Outpatient Surgery/Procedures Facility Fee			5%	15%	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			5%	15%	Not Covered
Inpatient Hospitalization Facility Fees			5%	15%	Not Covered
Inpatient Physician/Surgeon Fees			5%	15%	Not Covered
Rehabilitative and Habilitative Services					
Outpatient Rehabilitation Services			5%	15%	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			5%	15%	Not Covered
Home Health			5%	15%	Not Covered
Diagnostic Services					
MRI and CT Scans			*\$100 per test	15%	Not Covered
Laboratory and X-rays			*\$20 per test	15%	Not Covered

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	*\$20 per visit	Not Covered
	Inpatient Services	5%	15%	Not Covered
Prescription Drugs				
<i>30 day supply</i>				
	Tier 1 - Preferred Generic/Preventive	*\$0	*\$0	Not Covered
	Tier 2 - Non-Preferred Generic	*\$10	*\$10	Not Covered
	Tier 3 - Preferred Brand	*\$35	*\$35	Not Covered
	Tier 4 - Non-Preferred Brand	*\$70	*\$70	Not Covered
	Tier 5 - Preferred Specialty	*50%	*50%	Not Covered
	Tier 6 - Non-Preferred Specialty	*50%	*50%	Not Covered
	Tier 7 - Medical Drugs	*50%	*50%	Not Covered
Maternity				
<i>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.</i>				
	Routine Prenatal Care	5%	15%	Not Covered
	Maternity Inpatient	5%	15%	Not Covered
	Newborn Care	5%	15%	Not Covered
Pediatric Services				
<i>(members up to the age of 19 years old)</i>				
	Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
	Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
	Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
	Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
	Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
	Pediatric Vision Exam	*\$0 per exam	*\$0 per exam	Not Covered
	Pediatric Vision Materials	*\$0 per item	*\$0 per item	Not Covered
Preventive and Wellness Services				
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.</i>				
	Wellness Care	*\$0	*\$0	Not Covered
Other Services				
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>				
	Other Covered Services	5%	15%	Not Covered
	Durable Medical Equipment	5%	15%	Not Covered

* 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 or request a copy by contacting the customer service number on the back of your ID card.