Health Alliance

Simplete Memorial HMO 2000 Gold

			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	$2,000	$3,500	Not Applicable
Embedded		Family	$4,000	$7,000	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	$4,000	$7,900	Not Applicable
		Family	$8,000	$15,800	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	*$25 per visit	Not Covered
Specialty Care Physician Office Visits			*$35 per visit	*$35 per visit	Not Covered
Spinal Manipulations			*$35 per visit	*$35 per visit	Not Covered
Urgent Care Visits			*$35 per visit	*$60 per visit	In Network Benefit Applies
Allergy Treatment and Testing			10%	20%	Not Covered
Emergency Services					
Emergency Department Visits			*$350 per visit	*$350 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			10%	10%	In Network Benefit Applies
Hospital Services					
Outpatient Surgery/Procedures Facility Fee			10%	20%	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			10%	20%	Not Covered
Inpatient Hospitalization Facility Fees			10%	20%	Not Covered
Inpatient Physician/Surgeon Fees			10%	20%	Not Covered
Rehabilitative and Habilitative Services					
Outpatient Rehabilitation Services			10%	20%	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			10%	20%	Not Covered
Home Health			10%	20%	Not Covered
Diagnostic Services					
MRI and CT Scans			*$100 per test	20%	Not Covered
Laboratory and X-rays			*$20 per test	20%	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	*$25 per visit	Not Covered
Inpatient Services	10%	20%	Not Covered
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic/Preventive	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$10	*$10	Not Covered
Tier 3 - Preferred Brand	*$40	*$40	Not Covered
Tier 4 - Non-Preferred Brand	*$80	*$80	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			
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	10%	20%	Not Covered
Maternity Inpatient	10%	20%	Not Covered
Newborn Care	10%	20%	Not Covered
Pediatric Services			
(members up to the age of 19 years old)			
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			
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.			
Wellness Care	*$0	*$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	10%	20%	Not Covered
Durable Medical Equipment	10%	20%	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.