



Simplete Memorial POS 750 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	\$750	\$1,500	\$3,000
	Family	\$1,500	\$3,000	\$6,000
	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	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	Medical/Pharmacy Individual	\$2,500	\$4,000	\$15,500
	Family	\$5,000	\$8,000	\$31,000
Dental OOPM goes toward medical OOPM	Pediatric Dental Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
	Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		
	Spinal Manipulations (includes muscle manipulations)	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		
Ambulatory Patient Services				
	Vision Exam	*\$20 per exam	*\$20 per exam	50%
	Virtual Visits	*\$0 per visit	*\$0 per visit	Not Covered
	Primary Care Physician Office Visits	*\$0 per visit	*\$20 per visit	50%
	Specialty Care Physician Office Visits	*\$30 per visit	*\$30 per visit	50%
	Spinal Manipulations	*\$30 per visit	*\$30 per visit	50%
	Urgent Care Visits	*\$30 per visit	*\$50 per visit	In Network Benefit Applies
	Allergy Treatment and Testing	10%	20%	50%
Emergency Services				
	Emergency Department Visits	*\$300 per visit	*\$300 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation	10%	10%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	10%	20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services	10%	20%	50%
	Inpatient Hospitalization Facility Fees	10%	20%	50%
	Inpatient Physician/Surgeon Fees	10%	20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services	10%	20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility	10%	20%	50%
	Home Health	10%	20%	50%
Diagnostic Services				
	MRI and CT Scans	*\$100 per test	20%	50%
	Laboratory and X-rays	*\$20 per test	20%	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	*\$20 per visit	50%
Inpatient Services	10%	20%	50%
Prescription Drugs			
<i>30 day supply</i>			
Tier 1 - Preferred Generic/Preventive	*\$0	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$10	*\$10	50%
Tier 3 - Preferred Brand	*\$35	*\$35	50%
Tier 4 - Non-Preferred Brand	*\$70	*\$70	50%
Tier 5 - Preferred Specialty	*50%	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	*50%	50%
Tier 7 - Medical Drugs	*50%	*50%	50%
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	10%	20%	50%
Maternity Inpatient	10%	20%	50%
Newborn Care	10%	20%	50%
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	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	*\$0 per exam	*\$0 per exam
Pediatric Vision Materials	*\$0 per item	*\$0 per item	*\$0 per item
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	50%
Other Services			
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>			
Other Covered Services	10%	20%	50%
Durable Medical Equipment	10%	20%	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.