Health Alliance

Simplete Memorial POS 1500 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	$1,500	$3,000	$6,000
Embedded	Family	$3,000	$6,000	$12,000
	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	$4,500	$7,000	$18,500
	Family	$9,000	$14,000	$37,000
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	*$25 per visit	50%
Specialty Care Physician Office Visits		*$35 per visit	*$35 per visit	50%
Spinal Manipulations		*$35 per visit	*$35 per visit	50%
Urgent Care Visits		*$35 per visit	*$60 per visit	In Network Benefit Applies
Allergy Treatment and Testing		15%	25%	50%
Emergency Services				
Emergency Department Visits		*$350 per visit	*$350 per visit	In Network Benefit Applies
Emergency Ambulance Transportation		15%	15%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee		15%	25%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services		15%	25%	50%
Inpatient Hospitalization Facility Fees		15%	25%	50%
Inpatient Physician/Surgeon Fees		15%	25%	50%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services		15%	25%	50%
Inpatient Rehabilitation/Skilled Nursing Facility		15%	25%	50%
Home Health		15%	25%	50%
Diagnostic Services				
MRI and CT Scans		*$100 per test	20%	50%
Laboratory and X-rays		*$20 per test	25%	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	*$25 per visit	50%
Inpatient Services	15%	25%	50%
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic/Preventive	*$0	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	*$10	50%
Tier 3 - Preferred Brand	*$40	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	*$80	50%
Tier 5 - Preferred Specialty	*50%	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	*50%	50%
Tier 7 - Medical Drugs	*50%	*50%	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	15%	25%	50%
Maternity Inpatient	15%	25%	50%
Newborn Care	15%	25%	50%
Pediatric Services			
(members up to the age of 19 years old)			
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			
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.			
Wellness Care	*$0	*$0	50%
Other Services			
Other services covered within your policy and not otherwise specified on this summary or on the SBC.			
Other Covered Services	15%	25%	50%
Durable Medical Equipment	15%	25%	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.