



HMO 80 Rx27 NS11

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$0	Not Applicable
		Family	\$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$2,000	Not Applicable
		Family	\$4,000	Not Applicable
Contract Year Maximum Benefits				
	Cardiac Rehabilitation		36 OP session w/in 6 month of event	
	Outpatient Rehabilitation Services		60 visits per condition per plan year	
	Home Health		Unlimited with Pre-authorization	
	Vision Exam		Once every 12 months	
Ambulatory Patient Services				
	Vision Exam		\$40 per exam	Not Covered
	Primary Care Physician Office Visits		\$30 per visit^	Not Covered
	Specialty Care Physician Office Visits		\$60 per visit^	Not Covered
	Spinal Manipulations		\$20 per visit	Not Covered
	Urgent Care Visits		\$25 per visit^	\$25 per visit
	Allergy Treatment and Testing		20%	Not Covered
Emergency Services				
	Emergency Department Visits		\$250 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		\$100	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	Not Covered
	Outpatient Surgery/Procedures Physician/Surgeon Services		20%	Not Covered
	Inpatient Hospitalization Facility Fees		20%	Not Covered
	Inpatient Physician/Surgeon Fees		20%	Not Covered
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services		20%	Not Covered
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	Not Covered
	Home Health		20%	Not Covered
Diagnostic Services				
	MRI and CT Scans		20%	Not Covered
	Diagnostic Testing		20%	Not Covered
Mental Health/Substance Use Treatment				
	Outpatient Office Visits		\$30 per visit^	Not Covered
	Inpatient Services		20%	Not Covered
	Non-Serious Mental Health Care		See in network outpatient office visit or inpatient services benefit.	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
<i>30 day supply</i>		
Generic - Tier 1	\$15	Not Covered
Brand - Tier 2	30%	Not Covered
Non-Preferred Brand - Tier 3	50%	Not Covered
Preferred Specialty Pharmacy/Medical - Tier 4	20%	Not Covered
Non-Preferred Specialty Pharmacy/Medical - Tier 5	20%	Not Covered
Non-Formulary Specialty Pharmacy/Medical - Tier 6	20%	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	20%	Not Covered
Maternity Inpatient	20%	Not Covered
Newborn Care	20%	Not Covered
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screening & more. Age/frequency schedules apply.</i>		
Wellness Care	\$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	20%	Not Covered
Durable Medical Equipment	20%	Not Covered

^ 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.

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.