



**POS HSA 5000c Rx13**

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
<b>Plan Year Deductible Embedded</b>	<b>Medical</b>	Individual	\$5,000	\$10,000
		Family	\$10,000	\$30,000
	<b>Pharmacy</b>	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
<b>Plan Year Out-of-Pocket Maximum (OOPM)</b>				
<i>Combined medical and pharmacy expenses including deductible, coinsurance &amp; copayments.</i>	<b>Medical/Pharmacy</b>	Individual	\$6,250	\$12,500
		Family	\$12,500	\$37,500
<b>Contract Year Maximum Benefits</b>				
	Cardiac Rehabilitation		36 OP session 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	
	Home Health		Unlimited with Pre-authorization	
	Spinal Manipulations (includes muscle manipulations)		\$500 maximum per plan year combined in-net and OON	
	Temporomandibular Joint (TMJ) Treatment		\$2,500 maximum per plan year Out of Network	
	Vision Exam		Once every 12 months	
<b>Ambulatory Patient Services</b>				
	Vision Exam		\$40 per exam	Not Covered
	Primary Care Physician Office Visits		20%	50%
	Specialty Care Physician Office Visits		20%	50%
	Spinal Manipulations		20%	In Network Deductible Applies
	Urgent Care Visits		20%	50%
	Allergy Treatment and Testing		20%	50%
<b>Emergency Services</b>				
	Emergency Department Visits		20%	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
<b>Hospital Services</b>				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
<b>Rehabilitative and Habilitative Services</b>				
	Outpatient Rehabilitation Services		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
<b>Diagnostic Services</b>				
	MRI and CT Scans		20%	50%
	Diagnostic Testing		20%	50%
<b>Mental Health/Substance Use Treatment</b>				
	Outpatient Office Visits		20%	50%
	Inpatient Services		20%	50%
	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))
<b>Prescription Drugs</b>		
<i>30 day supply</i>		
Generic - Tier 1	20%	50%
Brand - Tier 2	20%	50%
Non-Preferred Brand - Tier 3	20%	50%
Preferred Specialty Pharmacy/Medical - Tier 4	20%	50%
Non-Preferred Specialty Pharmacy/Medical - Tier 5	20%	50%
Non-Formulary Specialty Pharmacy/Medical - Tier 6	20%	50%
<b>Maternity</b>		
<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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
<b>Preventive and Wellness Services</b>		
<i>Immunizations, adult &amp; child annual physical exams, mammograms, PAP smears, prostate screening &amp; more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
<b>Other Services</b>		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Durable Medical Equipment	20%	50%

\* Deductible does not apply

**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.

**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](http://www.healthalliance.org) or request a copy by contacting the customer service number on the back of your ID card.