

## PPO Short-term 5000

Member Benefits		In-Network	Out-of-Network
Plan Year Deductible		\$5,000	\$10,000
Plan Year Out-of-Pocket Maximum		\$10,000	\$20,000
<b>Walk-in Patient Services</b>	<i>Annual Vision Exam</i>	Not Covered	Not Covered
	<i>Primary Care Physician Office Visit</i>	Deductible, 20%	Deductible, 50%
	<i>Specialty Care Physician Office Visit</i>	Deductible, 20%	Deductible, 50%
	<i>Spinal Manipulations</i>	Not Covered	Not Covered
	<i>Urgent Care</i>	Deductible, 20%	In Network Benefit Applies
	<i>Virtual Visits</i>	First 3 visits \$0, Deductible then 20%	Not Covered
<b>Emergency Services</b>	<i>Emergency Department Visit</i>	\$500 per visit	In Network Benefit Applies
	<i>Emergency Ambulance Transportation</i>	\$100	
<b>Hospital Services</b>	<i>Outpatient Surgery/Procedures*</i>	Deductible, 20%	Deductible, 50%
	<i>Inpatient Facility*</i>	Deductible, 20%	Deductible, 50%
<b>Mental Health/Substance Abuse</b>	<i>Outpatient Office Visits</i>	Not Covered	Not Covered
	<i>Inpatient Facility*</i>	Not Covered	Not Covered
<b>Rehabilitative &amp; Habilitative Services</b>	<i>Physical Therapy</i>	Deductible, 20%	Deductible, 50%
	<i>Durable Medical Equipment</i>	20%**	50%**
<b>Diagnostic Services</b>	<i>MRI and CT Scans</i>	Deductible, 20%	Deductible, 50%
	<i>Laboratory and X-ray</i>	Deductible, 20%	Deductible, 50%
<b>Maternity</b> <i>Inpatient newborn covered on mother's policy up to 96 hours</i>	<i>Routine Prenatal Care</i>	Not Covered	Not Covered
	<i>Inpatient Maternity Facility*</i>	Not Covered	Not Covered
	<i>Inpatient Newborn Facility*</i>	Deductible, 20%	Deductible, 50%
<b>Preventive &amp; Wellness Services</b>		Deductible, 20%	Deductible, 50%
<i>Immunizations, adult and child annual physical exams, mammograms, PAP smears, cancer screenings and more. Age/frequency schedules apply.</i>			
<b>Prescription Drugs Retail</b>	<i>Generic – Tier 1</i>	\$20**	Not Covered
	<i>Preferred Brand Drugs – Tier 2</i>	Not Covered	Not Covered
	<i>Non-Preferred Brand Drugs – Tier 3</i>	Not Covered	Not Covered
<b>Specialty Pharmacy/Medical</b>	<i>Specialty Drugs - Preferred – Tier 4</i>	Not Covered	Not Covered
	<i>Specialty Drugs - Non-Preferred – Tier 5</i>	Not Covered	Not Covered
	<i>Specialty Drugs- Non-Formulary – Tier 6</i>	Not Covered	Not Covered

**This is a brief summary of Health Alliance benefits and exclusions, which are subject to change. Please refer to your Health Alliance policy for detailed information regarding this plan.**

\*Facility coverage only; physicians fees may apply  
 \*\*Does Not Apply to Out-of-Pocket Max  
 \$1,000,000 Benefit Period Maximum  
 \$500 Durable Medical Equipment/Orthotics Max  
 \$10,000 Prosthetic Max  
 PT 30 visits max