Health Care at 40-60% Savings

"The Rebirth of Healthcare"

Shared Health Alliance offers plan choices that provide a full range of health care access options.

	SHA Preventive Premier	SHA Preventive
Network	PHCS/MultiPlan with RBP Wrap	PHCS/MultiPlan with RBP Wrap
Deductible	No	No
Catastrophic Reimbursement	No	No
Preventive Care Services	100% (no deductible)	100% (no deductible)
Doctor Access	$0 Co-pay Telemedicine	$0 Co-pay Telemedicine
Primary Care Physician Office Visit (PHCS)	$20 Copay (max 3 visits per year)	Not covered
Specialist Office Visit (PHCS)	$50 Copay (max 3 visits per year)	Not Covered
Urgent Care (PHCS)	$50 Copay (max 3 visits per year)	Not Covered
Diagnostic X-ray and Lab (PHCS)	$50 Copay (In office, max 5 services)	Not Covered
Cat-Scan or MRI (PHCS)	$200 Copay (1 per year)	Not Covered
Outpatient Testing (PHCS)	$200 Copay (1 per year)	Not Covered
Prescription Benefits		
Tier 1 - $0-$49.99	10% Co-Insurance	10% Co-Insurance
Tier 2 - $50-$149.99	20% Co-Insurance	20% Co-Insurance
Tier 3 - $150-$400*	40% Co-Insurance	40% Co-Insurance
Specialty	SHARx	SHARx
Monthly Rate Schedule		
Single	$175	$119
Single + 1	$286	$189
Family	$373	$235

*High cost drugs only available through advocacy

DENTAL & VISION

SHA Healthy Essentials

Dental Benefits

Dental Plan Provisions	Member Pays
Calendar Year Deductible (Per Person / Per Family) (Applies to Class II, III and IV)	$50 / $150
Dental Plan Provisions	**Plan Pays**
Calendar Year Maximum (Applies to Class I, II and III - Services Combined)	$1,250
Lifetime Maximum (Applies to Class IV Services)	N/A
Dental Services	**Plan Pays**
Class I – Preventive Services	100% - no deductible
Class II – Basic Services (6 month waiting period)	80% - after calendar year deductible
Class III – Major Services (12 month waiting period)	50% - after calendar year deductible
Class IV – Orthodontic Services	N/A

*Eligible benefits based on Usual and Customary at the 90th percentile of the National Dental Advisory Service (NDAS) guidelines.

Vision Benefits

Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery	$250 per year, per covered member, combined benefit maximum

Monthly Rate Schedule	
Member Only	$48
Member and Spouse	$89
Member and Child(ren)	$105
Member and Family	$156

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.