Illinois

2025 Individual Marketplace Plans

Made for you.

The plans in this booklet are Marketplace plans. For more information, call the Health Alliance™ team at (877) 686-1168.

2025 HMO 9200 Elite Catastrophic

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$9,200	Not Applicable
Embedded		Family	$18,400	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	Not Applicable
		Family	$18,400	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	0%	Not Covered
		Primary Care Physician Office Visits	^$0 visits 1-3, then Deductible and 0%	Not Covered
		Virtual Primary Care Visit	0%	Not Covered
		Specialty Care Physician Office Visits	0%	Not Covered
		Chiropractic Services	0%	Not Covered
		Acupuncture	^$0 visits 1-3, then Deductible and 0%	Not Covered
		Urgent Care Visits	0%	In Network Benefit Applies
		Virtual Urgent Care Visits	0%	Not Covered
		Allergy Treatment and Testing	0%	Not Covered
Emergency Services				
		Emergency Department Visits	0%	In Network Benefit Applies
		Emergency Ambulance Transportation	0%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	0%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	0%	Not Covered
		Inpatient Hospitalization Facility Fees	0%	Not Covered
		Inpatient Physician/Surgeon Fees	0%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	0%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	0%	Not Covered
		Home Health	0%	Not Covered
Diagnostic Services				
		MRI and CT Scans	0%	Not Covered
		Laboratory	0%	Not Covered
		X-Ray	0%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	^$0 visits 1-3, then Deductible and 0%	Not Covered
Inpatient Services	0%	Not Covered
Virtual Mental Health Visits	0%	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	0%	Not Covered
Tier 2 - Non-Preferred Generic	0%	Not Covered
Tier 3 - Preferred Brand	0%	Not Covered
Tier 4 - Non-Preferred Brand	0%	Not Covered
Tier 5 - Preferred Specialty	0%	Not Covered
Tier 6 - Non-Preferred Specialty	0%	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	0%	Not Covered
Maternity Inpatient	0%	Not Covered
Newborn Care	0%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	0%	Not Covered
Major Dental Services	0%	Not Covered
Medically Necessary Orthodontia Services	*0%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	Not Covered
Abortion Procedure Facility Fee	0%	Not Covered
Abortion Procedure Physician Fee	0%	Not Covered
Durable Medical Equipment	0%	Not Covered

^ Copay applies before the Deductible

* 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.

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.

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2025 POS 1000 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,000	$2,000
Embedded		Family	$2,000	$4,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,500	$14,500
		Family	$13,000	$29,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$20 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$50 per visit	50%
		Chiropractic Services	*$50 per visit	In Network Benefit Applies
		Acupuncture	*$20 per visit	In Network Benefit Applies
		Urgent Care Visits	*$50 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	50%
Emergency Services				
		Emergency Department Visits	*$1,500 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	30%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	30%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	*$1,500 per procedure	50%
		Inpatient Hospitalization Facility Fees	^$1,500 per stay and Deductible then 30%	50%
		Inpatient Physician/Surgeon Fees	30%	50%
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	30%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	50%
		Home Health	30%	50%
Diagnostic Services				
		MRI and CT Scans	30%	50%
		Laboratory	*$500 per test	50%
		X-Ray	*$500 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$20 per visit	50%
Inpatient Services	^$1,500 per stay and Deductible then 30%	50%
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	30%	50%
Maternity Inpatient	^$1,500 per stay and Deductible then 30%	50%
Newborn Care	^$1,500 per stay and Deductible then 30%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	30%	50%
Abortion Procedure Facility Fee	30%	50%
Abortion Procedure Physician Fee	*$1,500 per procedure	50%
Durable Medical Equipment	30%	50%

* Deductible does not apply
^ Copay applies before the Deductible
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.

Health Alliance™

2025 POS 1000 Elite Gold Ind CSR

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$1,000	$2,000
Embedded	Family	$0	$2,000	$4,000
	Pharmacy Individual	$0	Not Applicable	Not Applicable
	Family	$0	Not Applicable	Not Applicable
	Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$6,500	$14,500
	Family	$0	$13,000	$29,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$350	Not Applicable
	Family	$0	$700	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0 per visit	30%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	*$1,500 per procedure	50%
	Inpatient Hospitalization Facility Fees	$0 per stay	^$1,500 per stay and Deductible then 30%	50%
	Inpatient Physician/Surgeon Fees	$0 per procedure	30%	50%
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	*$20 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	*$20 per visit	50%
	Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	*$50 per visit	50%
	Chiropractic Services	$0 per visit	*$50 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	*$20 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	*$50 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	30%	50%
Emergency Services				
	Emergency Department Visits	$0 per visit	*$1500 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	30%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	30%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	30%	50%
	Home Health	$0	30%	50%
Diagnostic Services				
	MRI and CT Scans	$0 per test	30%	50%
	Laboratory	$0 per test	*$500 per test	50%
	X-Ray	$0 per test	*$500 per test	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	*$20 per visit	50%
Inpatient Services	$0 per stay	^$1,500 per stay and Deductible then 30%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$0	50%
Tier 2 - Non-Preferred Generic	$0	*$10	50%
Tier 3 - Preferred Brand	$0	*$40	50%
Tier 4 - Non-Preferred Brand	$0	*$80	50%
Tier 5 - Preferred Specialty	$0	*$250	50%
Tier 6 - Non-Preferred Specialty	$0	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	30%	50%
Maternity Inpatient	$0 per stay	^$1,500 per stay and Deductible then 30%	50%
Newborn Care	$0 per stay	^$1,500 per stay and Deductible then 30%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	30%	50%
Abortion Procedure Facility Fee	$0	30%	50%
Abortion Procedure Physician Fee	$0 per procedure	*$1,500 per procedure	50%
Durable Medical Equipment	$0	30%	50%

* Deductible does not apply
^ Copay applies before the Deductible
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.

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Health Alliance™

2025 POS 1000 Elite Gold Ind CSR 0

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$0	$0
Embedded	Family	$0	$0	$0
	Pharmacy Individual	Not Applicable	Not Applicable	Not Applicable
	Family	Not Applicable	Not Applicable	Not Applicable
	Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$0	$0
	Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$0	Not Applicable
	Family	$0	$0	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0
	Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
	Inpatient Physician/Surgeon Fees	$0	$0	$0
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	$0 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	$0	$0
Emergency Services				
	Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
	Home Health	$0	$0	$0
Diagnostic Services				
	MRI and CT Scans	$0 per test	$0 per test	$0 per test
	Laboratory	$0 per test	$0 per test	$0 per test
	X-Ray	$0 per test	$0 per test	$0 per test

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	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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.

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2025 POS 1500 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,500	$3,000
Embedded		Family	$3,000	$6,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,800	$15,500
		Family	$15,600	$31,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	25%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	25%	50%
		Inpatient Hospitalization Facility Fees	25%	50%
		Inpatient Physician/Surgeon Fees	25%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$30 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$60 per visit	50%
		Chiropractic Services	*$60 per visit	In Network Benefit Applies
		Acupuncture	*$30 per visit	In Network Benefit Applies
		Urgent Care Visits	*$45 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	25%	50%
Emergency Services				
		Emergency Department Visits	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	25%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$30 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	25%	50%
		Home Health	25%	50%
Diagnostic Services				
		MRI and CT Scans	25%	50%
		Laboratory	25%	50%
		X-Ray	25%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	50%
Inpatient Services	25%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$15	50%
Tier 2 - Non-Preferred Generic	*$15	50%
Tier 3 - Preferred Brand	*$30	50%
Tier 4 - Non-Preferred Brand	*$60	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$250	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	25%	50%
Maternity Inpatient	25%	50%
Newborn Care	25%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	50%
Abortion Procedure Facility Fee	25%	50%
Abortion Procedure Physician Fee	25%	50%
Durable Medical Equipment	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.

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2025 POS 1500 Elite Gold Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$1,500	$3,000
Embedded		Family	$0	$3,000	$6,000
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$7,800	$15,500
		Family	$0	$15,600	$31,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	25%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	25%	50%
		Inpatient Hospitalization Facility Fees	$0 per stay	25%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	25%	50%
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$30 per visit	50%
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$60 per visit	50%
		Chiropractic Services	$0 per visit	*$60 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	*$30 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	*$45 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	25%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	25%	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$30 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	25%	50%
		Home Health	$0	25%	50%
Diagnostic Services					
		MRI and CT Scans	$0 per test	25%	50%
		Laboratory	$0 per test	25%	50%
		X-Ray	$0 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	*$30 per visit	50%
Inpatient Services	$0 per stay	25%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$15	50%
Tier 2 - Non-Preferred Generic	$0	*$15	50%
Tier 3 - Preferred Brand	$0	*$30	50%
Tier 4 - Non-Preferred Brand	$0	*$60	50%
Tier 5 - Preferred Specialty	$0	*$250	50%
Tier 6 - Non-Preferred Specialty	$0	*$250	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	25%	50%
Maternity Inpatient	$0 per stay	25%	50%
Newborn Care	$0 per stay	25%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	25%	50%
Abortion Procedure Facility Fee	$0	25%	50%
Abortion Procedure Physician Fee	$0	25%	50%
Durable Medical Equipment	$0	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.

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Health Alliance™

2025 POS 1500 Elite Gold Ind CSR 0

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$0	$0
Embedded	Family	$0	$0	$0
	Pharmacy Individual	Not Applicable	Not Applicable	Not Applicable
	Family	Not Applicable	Not Applicable	Not Applicable
	Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$0	$0
	Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$0	Not Applicable
	Family	$0	$0	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0
	Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
	Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	$0 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	$0	$0
Emergency Services				
	Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
	Home Health	$0	$0	$0
Diagnostic Services				
	MRI and CT Scans	$0 per test	$0 per test	$0 per test
	Laboratory	$0 per test	$0 per test	$0 per test
	X-Ray	$0 per test	$0 per test	$0 per test

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	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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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.

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2025 HMO 1500 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,500	Not Applicable
Embedded		Family	$3,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,800	Not Applicable
		Family	$15,600	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$30 per visit	Not Covered
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$60 per visit	Not Covered
		Chiropractic Services	*$60 per visit	Not Covered
		Acupuncture	*$30 per visit	Not Covered
		Urgent Care Visits	*$45 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	25%	Not Covered
Emergency Services				
		Emergency Department Visits	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	25%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	25%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	25%	Not Covered
		Inpatient Hospitalization Facility Fees	25%	Not Covered
		Inpatient Physician/Surgeon Fees	25%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$30 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	25%	Not Covered
		Home Health	25%	Not Covered
Diagnostic Services				
		MRI and CT Scans	25%	Not Covered
		Laboratory	25%	Not Covered
		X-Ray	25%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	Not Covered
Inpatient Services	25%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$15	Not Covered
Tier 2 - Non-Preferred Generic	*$15	Not Covered
Tier 3 - Preferred Brand	*$30	Not Covered
Tier 4 - Non-Preferred Brand	*$60	Not Covered
Tier 5 - Preferred Specialty	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	*$250	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	25%	Not Covered
Maternity Inpatient	25%	Not Covered
Newborn Care	25%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	Not Covered
Abortion Procedure Facility Fee	25%	Not Covered
Abortion Procedure Physician Fee	25%	Not Covered
Durable Medical Equipment	25%	Not Covered

* Deductible does not apply

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2025 HMO 1500 Elite Gold Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$1,500	Not Applicable
Embedded		Family	$0	$3,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$7,800	Not Applicable
		Family	$0	$15,600	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$30 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$60 per visit	Not Covered
		Chiropractic Services	$0 per visit	*$60 per visit	Not Covered
		Acupuncture	$0 per visit	*$30 per visit	Not Covered
		Urgent Care Visits	$0 per visit	*$45 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	25%	Not Covered
Emergency Services					
		Emergency Department Visits	$0 per visit	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	25%	In Network Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	25%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	25%	Not Covered
		Inpatient Hospitalization Facility Fees	$0 per stay	25%	Not Covered
		Inpatient Physician/Surgeon Fees	$0 per procedure	25%	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$30 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	25%	Not Covered
		Home Health	$0	25%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	25%	50%
Laboratory	$0 per test	25%	Not Covered
X-Ray	$0 per test	25%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	*$30 per visit	Not Covered
Inpatient Services	$0 per stay	25%	Not Covered
Virtual Mental Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$15	Not Covered
Tier 2 - Non-Preferred Generic	$0	*$15	Not Covered
Tier 3 - Preferred Brand	$0	*$30	Not Covered
Tier 4 - Non-Preferred Brand	$0	*$60	Not Covered
Tier 5 - Preferred Specialty	$0	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	$0	*$250	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	25%	Not Covered
Maternity Inpatient	$0 per stay	25%	Not Covered
Newborn Care	$0 per stay	25%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.*			
Wellness Care	$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	25%	Not Covered
Abortion Procedure Facility Fee	$0	25%	Not Covered
Abortion Procedure Physician Fee	$0	25%	Not Covered
Durable Medical Equipment	$0	25%	Not Covered

* 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.

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2025 HMO 1500 Elite Gold Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	Not Applicable
Embedded		Family	$0	$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	Not Covered
		Chiropractic Services	$0 per visit	$0 per visit	Not Covered
		Acupuncture	$0 per visit	$0 per visit	Not Covered
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	Not Covered
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	Not Covered
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	Not Covered
		Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	Not Covered
		Home Health	$0	$0	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	$0 per test
Laboratory	$0 per test	$0 per test	Not Covered
X-Ray	$0 per test	$0 per test	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	Not Covered
Inpatient Services	$0 per stay	$0 per stay	Not Covered
Virtual Mental Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	$0	Not Covered
Tier 3 - Preferred Brand	$0	$0	Not Covered
Tier 4 - Non-Preferred Brand	$0	$0	Not Covered
Tier 5 - Preferred Specialty	$0	$0	Not Covered
Tier 6 - Non-Preferred Specialty	$0	$0	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	Not Covered
Maternity Inpatient	$0 per stay	$0 per stay	Not Covered
Newborn Care	$0 per stay	$0 per stay	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	Not Covered
Abortion Procedure Facility Fee	$0	$0	Not Covered
Abortion Procedure Physician Fee	$0	$0	Not Covered
Durable Medical Equipment	$0	$0	Not Covered

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.

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2025 POS 2500 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,500	$5,000
Embedded		Family	$5,000	$10,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,900	$17,500
		Family	$13,800	$35,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	15%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	15%	50%
		Inpatient Hospitalization Facility Fees	15%	50%
		Inpatient Physician/Surgeon Fees	15%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$25 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$50 per visit	50%
		Chiropractic Services	*$50 per visit	In Network Benefit Applies
		Acupuncture	*$25 per visit	In Network Benefit Applies
		Urgent Care Visits	*$50 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	15%	50%
Emergency Services				
		Emergency Department Visits	15%	In Network Benefit Applies
		Emergency Ambulance Transportation	15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	15%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	15%	50%
		Home Health	15%	50%
Diagnostic Services				
		MRI and CT Scans	15%	50%
		Laboratory	*$100 per test	50%
		X-Ray	*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$25 per visit	50%
Inpatient Services	15%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$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%	50%
Abortion Procedure Facility Fee	15%	50%
Abortion Procedure Physician Fee	15%	50%
Durable Medical Equipment	15%	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.

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2025 POS 2500 Elite Gold Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$2,500	$5,000
Embedded		Family	$0	$5,000	$10,000
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$6,900	$17,500
		Family	$0	$13,800	$35,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	15%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	15%	50%
		Inpatient Hospitalization Facility Fees	$0 per stay	15%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	15%	50%
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$25 per visit	50%
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$50 per visit	50%
		Chiropractic Services	$0 per visit	*$50 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	*$25 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	*$50 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	15%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	15%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	15%	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	15%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	15%	50%
		Home Health	$0	15%	50%
Diagnostic Services					
		MRI and CT Scans	$0 per test	15%	50%
		Laboratory	$0 per test	*$100 per test	50%
		X-Ray	$0 per test	*$200 per test	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	$0 per stay	15%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$0	50%
Tier 2 - Non-Preferred Generic	$0	*$10	50%
Tier 3 - Preferred Brand	$0	*$40	50%
Tier 4 - Non-Preferred Brand	$0	*$80	50%
Tier 5 - Preferred Specialty	$0	*$250	50%
Tier 6 - Non-Preferred Specialty	$0	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	15%	50%
Maternity Inpatient	$0 per stay	15%	50%
Newborn Care	$0 per stay	15%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	15%	50%
Abortion Procedure Facility Fee	$0	15%	50%
Abortion Procedure Physician Fee	$0	15%	50%
Durable Medical Equipment	$0	15%	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.

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Health Alliance™

2025 POS 2500 Elite Gold Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0
Embedded		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0	$0	$0
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0
Diagnostic Services					
		MRI and CT Scans	$0 per test	$0 per test	$0 per test
		Laboratory	$0 per test	$0 per test	$0 per test
		X-Ray	$0 per test	$0 per test	$0 per test

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	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services			
(members up to the age of 19 years old)			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services			
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.			
Wellness Care	$0	$0	$0
Other Services			
Other services covered within your policy and not otherwise specified on this summary or on the SBC.			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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.

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2025 POS 4200 Elite Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$4,200	$8,400
Embedded		Family	$8,400	$16,800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$20,900
		Family	$18,400	$41,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	50%
		Inpatient Hospitalization Facility Fees	40%	50%
		Inpatient Physician/Surgeon Fees	40%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$55 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	50%
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$50 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	50%
		Home Health	40%	50%
Diagnostic Services				
		MRI and CT Scans	40%	50%
		Laboratory	*$150 per test	50%
		X-Ray	*$300 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$0	50%
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	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.

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2025 POS 4200 Elite Silver Ind CSR

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$4,200	$8,400
Embedded	Family	$0	$8,400	$16,800
	Pharmacy Individual	$0	Not Applicable	Not Applicable
	Family	$0	Not Applicable	Not Applicable
	Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$9,200	$20,900
	Family	$0	$18,400	$41,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$350	Not Applicable
	Family	$0	$700	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0 per visit	40%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	40%	50%
	Inpatient Hospitalization Facility Fees	$0 per stay	40%	50%
	Inpatient Physician/Surgeon Fees	$0 per procedure	40%	50%
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	*$20 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	*$40 per visit	50%
	Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	*$80 per visit	50%
	Chiropractic Services	$0 per visit	*$80 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	*$40 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	*$55 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	40%	50%
Emergency Services				
	Emergency Department Visits	$0 per visit	40%	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$50 per visit	50%
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	40%	50%
	Home Health	$0	40%	50%
Diagnostic Services				
	MRI and CT Scans	$0 per test	40%	50%
	Laboratory	$0 per test	*$150 per test	50%
	X-Ray	$0 per test	*$300 per test	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	*$40 per visit	50%
Inpatient Services	$0 per stay	40%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$0	50%
Tier 2 - Non-Preferred Generic	$0	*$10	50%
Tier 3 - Preferred Brand	$0	*$40	50%
Tier 4 - Non-Preferred Brand	$0	*$80	50%
Tier 5 - Preferred Specialty	$0	*$250	50%
Tier 6 - Non-Preferred Specialty	$0	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	40%	50%
Maternity Inpatient	$0 per stay	40%	50%
Newborn Care	$0 per stay	40%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	40%	50%
Abortion Procedure Facility Fee	$0	40%	50%
Abortion Procedure Physician Fee	$0	40%	50%
Durable Medical Equipment	$0	40%	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.

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2025 POS 4200 Elite Silver Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible Embedded	**Medical**	Individual	$0	$0	$0
		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0
Diagnostic Services					
		MRI and CT Scans	$0 per test	$0 per test	$0 per test
		Laboratory	$0 per test	$0 per test	$0 per test
		X-Ray	$0 per test	$0 per test	$0 per test

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	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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.

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2025 POS 4200 Elite Silver CSR 73

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$4,100	$8,200
Embedded		Family	$8,200	$16,400
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,350	$20,700
		Family	$14,700	$41,400
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	50%
		Inpatient Hospitalization Facility Fees	40%	50%
		Inpatient Physician/Surgeon Fees	40%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$55 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	50%
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$50 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	50%
		Home Health	40%	50%
Diagnostic Services				
		MRI and CT Scans	40%	50%
		Laboratory	*$150 per test	50%
		X-Ray	*$300 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$0	50%
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	50%

* Deductible does not apply

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2025 POS 4200 Elite Silver CSR 87

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,000	$2,000
Embedded		Family	$2,000	$4,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,400	$14,500
		Family	$4,800	$29,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	50%
		Inpatient Hospitalization Facility Fees	40%	50%
		Inpatient Physician/Surgeon Fees	40%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$35 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$55 per visit	50%
		Chiropractic Services	*$55 per visit	In Network Benefit Applies
		Acupuncture	*$35 per visit	In Network Benefit Applies
		Urgent Care Visits	*$55 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	50%
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$50 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	50%
		Home Health	40%	50%
Diagnostic Services				
		MRI and CT Scans	40%	50%
		Laboratory	*$150 per test	50%
		X-Ray	*$300 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$35 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	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.

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2025 POS 4200 Elite Silver CSR 94

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$450	$900
Embedded		Family	$900	$1,800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$900	$13,400
		Family	$1,800	$26,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	5%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	5%	50%
		Inpatient Hospitalization Facility Fees	5%	50%
		Inpatient Physician/Surgeon Fees	5%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$10 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$20 per visit	50%
		Chiropractic Services	*$20 per visit	In Network Benefit Applies
		Acupuncture	*$10 per visit	In Network Benefit Applies
		Urgent Care Visits	*$20 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	5%	50%
Emergency Services				
		Emergency Department Visits	5%	In Network Benefit Applies
		Emergency Ambulance Transportation	5%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$40 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	5%	50%
		Home Health	5%	50%
Diagnostic Services				
		MRI and CT Scans	5%	50%
		Laboratory	*$50 per test	50%
		X-Ray	*$50 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$10 per visit	50%
Inpatient Services	5%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	5%	50%
Maternity Inpatient	5%	50%
Newborn Care	5%	50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$0	50%
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*		
Other Covered Services	5%	50%
Abortion Procedure Facility Fee	5%	50%
Abortion Procedure Physician Fee	5%	50%
Durable Medical Equipment	5%	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.

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2025 POS 5000 Elite Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$5,000	$10,000
Embedded		Family	$10,000	$20,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,000	$22,500
		Family	$16,000	$45,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	50%
		Inpatient Hospitalization Facility Fees	40%	50%
		Inpatient Physician/Surgeon Fees	40%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	50%
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$40 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	50%
		Home Health	40%	50%
Diagnostic Services				
		MRI and CT Scans	40%	50%
		Laboratory	40%	50%
		X-Ray	40%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$20	50%
Tier 2 - Non-Preferred Generic	*$20	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	$80	50%
Tier 5 - Preferred Specialty	$350	50%
Tier 6 - Non-Preferred Specialty	$350	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	50%

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2025 POS 5000 Elite Silver Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$5,000	$10,000
Embedded		Family	$0	$10,000	$20,000
	Pharmacy	Individual	$0	Not Applicable	Not Applicable
		Family	$0	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$8,000	$22,500
		Family	$0	$16,000	$45,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	40%	50%
		Inpatient Hospitalization Facility Fees	$0 per stay	40%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	40%	50%
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$40 per visit	50%
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$80 per visit	50%
		Chiropractic Services	$0 per visit	*$80 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	40%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$40 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0	40%	50%
		Home Health	$0	40%	50%
Diagnostic Services					
		MRI and CT Scans	$0	40%	50%
		Laboratory	$0 per test	40%	50%
		X-Ray	$0 per test	40%	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	*$40 per visit	50%
Inpatient Services	$0 per stay	40%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$20	50%
Tier 2 - Non-Preferred Generic	$0	*$20	50%
Tier 3 - Preferred Brand	$0	*$40	50%
Tier 4 - Non-Preferred Brand	$0	$80	50%
Tier 5 - Preferred Specialty	$0	$350	50%
Tier 6 - Non-Preferred Specialty	$0	$350	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	40%	50%
Maternity Inpatient	$0 per stay	40%	50%
Newborn Care	$0 per stay	40%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	40%	50%
Abortion Procedure Facility Fee	$0 per visit	40%	50%
Abortion Procedure Physician Fee	$0	40%	50%
Durable Medical Equipment	$0	40%	50%

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2025 POS 5000 Elite Silver Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0
Embedded		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0	$0	$0
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0
Diagnostic Services					
		MRI and CT Scans	$0 per test	$0 per test	$0 per test
		Laboratory	$0 per test	$0 per test	$0 per test
		X-Ray	$0 per test	$0 per test	$0 per test

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	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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.

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2025 POS 5000 Elite Silver CSR 73

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,000	$6,000
Embedded		Family	$6,000	$12,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,400	$18,500
		Family	$12,800	$37,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	50%
		Inpatient Hospitalization Facility Fees	40%	50%
		Inpatient Physician/Surgeon Fees	40%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	50%
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$40 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	50%
		Home Health	40%	50%
Diagnostic Services				
		MRI and CT Scans	40%	50%
		Laboratory	40%	50%
		X-Ray	40%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$20	50%
Tier 2 - Non-Preferred Generic	*$20	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	$80	50%
Tier 5 - Preferred Specialty	$350	50%
Tier 6 - Non-Preferred Specialty	$350	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	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.

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2025 POS 5000 Elite Silver CSR 87

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$500	$1,000
Embedded		Family	$1,000	$2,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$3,000	$13,500
		Family	$6,000	$27,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	30%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	30%	50%
		Inpatient Hospitalization Facility Fees	30%	50%
		Inpatient Physician/Surgeon Fees	30%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$20 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$40 per visit	50%
		Chiropractic Services	*$40 per visit	In Network Benefit Applies
		Acupuncture	*$20 per visit	In Network Benefit Applies
		Urgent Care Visits	*$30 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	50%
Emergency Services				
		Emergency Department Visits	30%	In Network Benefit Applies
		Emergency Ambulance Transportation	30%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$20 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	50%
		Home Health	30%	50%
Diagnostic Services				
		MRI and CT Scans	30%	50%
		Laboratory	30%	50%
		X-Ray	30%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$20 per visit	50%
Inpatient Services	30%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$10	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$20	50%
Tier 4 - Non-Preferred Brand	$60	50%
Tier 5 - Preferred Specialty	$250	50%
Tier 6 - Non-Preferred Specialty	$250	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	30%	50%
Maternity Inpatient	30%	50%
Newborn Care	30%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	30%	50%
Abortion Procedure Facility Fee	30%	50%
Abortion Procedure Physician Fee	30%	50%
Durable Medical Equipment	30%	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.

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2025 POS 5000 Elite Silver CSR 94

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$0	$0
Embedded		Family	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,000	$12,500
		Family	$4,000	$25,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	*25%	*50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	*25%	*50%
		Inpatient Hospitalization Facility Fees	*25%	*50%
		Inpatient Physician/Surgeon Fees	*25%	*50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$0 per visit	*50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$10 per visit	*50%
		Chiropractic Services	*$10 per visit	In Network Benefit Applies
		Acupuncture	*$0 per visit	In Network Benefit Applies
		Urgent Care Visits	*$5 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	*25%	*50%
Emergency Services				
		Emergency Department Visits	*25%	In Network Benefit Applies
		Emergency Ambulance Transportation	*25%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$0 per visit	*50%
		Inpatient Rehabilitation/Skilled Nursing Facility	*25%	*50%
		Home Health	*25%	*50%
Diagnostic Services				
		MRI and CT Scans	*25%	*50%
		Laboratory	*25%	*50%
		X-Ray	*25%	*50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$0 per visit	*50%
Inpatient Services	*25%	*50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$0	*50%
Tier 2 - Non-Preferred Generic	*$0	*50%
Tier 3 - Preferred Brand	*$15	*50%
Tier 4 - Non-Preferred Brand	*$50	*50%
Tier 5 - Preferred Specialty	*$150	*50%
Tier 6 - Non-Preferred Specialty	*$150	*50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	*25%	*50%
Maternity Inpatient	*25%	*50%
Newborn Care	*25%	*50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$0	*50%
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*		
Other Covered Services	*25%	*50%
Abortion Procedure Facility Fee	*25%	*50%
Abortion Procedure Physician Fee	*25%	*50%
Durable Medical Equipment	*25%	*50%

* Deductible does not apply

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2025 HMO 5000 Elite Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$5,000	Not Applicable
Embedded		Family	$10,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,000	Not Applicable
		Family	$16,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	Not Covered
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	Not Covered
		Chiropractic Services	*$80 per visit	Not Covered
		Acupuncture	*$40 per visit	Not Covered
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	Not Covered
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	Not Covered
		Inpatient Hospitalization Facility Fees	40%	Not Covered
		Inpatient Physician/Surgeon Fees	40%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$40 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	Not Covered
		Home Health	40%	Not Covered
Diagnostic Services				
		MRI and CT Scans	40%	Not Covered
		Laboratory	40%	Not Covered
		X-Ray	40%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	Not Covered
Inpatient Services	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$20	Not Covered
Tier 2 - Non-Preferred Generic	*$20	Not Covered
Tier 3 - Preferred Brand	*$40	Not Covered
Tier 4 - Non-Preferred Brand	$80	Not Covered
Tier 5 - Preferred Specialty	$350	Not Covered
Tier 6 - Non-Preferred Specialty	$350	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	Not Covered
Maternity Inpatient	40%	Not Covered
Newborn Care	40%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	Not Covered
Abortion Procedure Facility Fee	40%	Not Covered
Abortion Procedure Physician Fee	40%	Not Covered
Durable Medical Equipment	40%	Not Covered

* Deductible does not apply

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2025 HMO 5000 Elite Silver Ind CSR

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$5,000	Not Applicable
Embedded	Family	$0	$10,000	Not Applicable
	Pharmacy Individual	$0	Not Applicable	Not Applicable
	Family	$0	Not Applicable	Not Applicable
	Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$8,000	Not Applicable
	Family	$0	$16,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$350	Not Applicable
	Family	$0	$700	Not Applicable
Contract Year Maximum Benefits				
	Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
	Outpatient Rehabilitation Services	60 visits per condition per plan year		
	Habilitative Services	60 visits per condition per plan year		
	Chiropractic Services	25 visits per plan year.		
	Adult Vision Exam	Once every 12 months		
	Acupuncture Treatment	15 visits per plan year		
	Pediatric Vision Exam	Once every 12 months		
	Pediatric Vision Materials	Once every 12 months.		
	Pediatric Dental Exam	Once every 6 months.		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	*$20 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	*$40 per visit	Not Covered
	Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	*$80 per visit	Not Covered
	Chiropractic Services	$0 per visit	*$80 per visit	Not Covered
	Acupuncture	$0 per visit	*$40 per visit	Not Covered
	Urgent Care Visits	$0 per visit	*$60 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	40%	Not Covered
Emergency Services				
	Emergency Department Visits	$0 per visit	40%	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	40%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0 per visit	40%	Not Covered
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0	40%	Not Covered
	Inpatient Hospitalization Facility Fees	$0 per stay	40%	Not Covered
	Inpatient Physician/Surgeon Fees	$0 per procedure	40%	Not Covered
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$40 per visit	Not Covered
	Inpatient Rehabilitation/Skilled Nursing Facility	$0	40%	Not Covered
	Home Health	$0	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0	40%	Not Covered
Laboratory	$0 per test	40%	Not Covered
X-Ray	$0 per test	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	*$40 per visit	Not Covered
Inpatient Services	$0 per stay	40%	Not Covered
Virtual Mental Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$20	Not Covered
Tier 2 - Non-Preferred Generic	$0	*$20	Not Covered
Tier 3 - Preferred Brand	$0	*$40	Not Covered
Tier 4 - Non-Preferred Brand	$0	$80	Not Covered
Tier 5 - Preferred Specialty	$0	$350	Not Covered
Tier 6 - Non-Preferred Specialty	$0	$350	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	40%	Not Covered
Maternity Inpatient	$0 per stay	40%	Not Covered
Newborn Care	$0 per stay	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.*			
Wellness Care	$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services Abortion Procedure Facility Fee Abortion	$0	40%	Not Covered
Procedure Physician Fee * Deductible does not apply	$0 per visit	40%	Not Covered
Durable Medical	$0	40%	Not Covered
Equipment	$0	40%	Not Covered

* 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.

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2025 HMO 5000 Elite Silver Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	Not Applicable
Embedded		Family	$0	$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	Not Covered
		Chiropractic Services	$0 per visit	$0 per visit	Not Covered
		Acupuncture	$0 per visit	$0 per visit	Not Covered
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	Not Covered
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	Not Covered
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	Not Covered
		Inpatient Physician/Surgeon Fees	$0	$0	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	Not Covered
		Home Health	$0	$0	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	Not Covered
Laboratory	$0 per test	$0 per test	Not Covered
X-Ray	$0 per test	$0 per test	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	Not Covered
Inpatient Services	$0 per stay	$0 per stay	Not Covered
Virtual Mental Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	$0	Not Covered
Tier 3 - Preferred Brand	$0	$0	Not Covered
Tier 4 - Non-Preferred Brand	$0	$0	Not Covered
Tier 5 - Preferred Specialty	$0	$0	Not Covered
Tier 6 - Non-Preferred Specialty	$0	$0	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	Not Covered
Maternity Inpatient	$0 per stay	$0 per stay	Not Covered
Newborn Care	$0 per stay	$0 per stay	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	Not Covered
Abortion Procedure Facility Fee	$0	$0	Not Covered
Abortion Procedure Physician Fee	$0	$0	Not Covered
Durable Medical Equipment	$0	$0	Not Covered

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.

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2025 HMO 5000 Elite Silver CSR 73

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,000	Not Applicable
Embedded		Family	$6,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,400	Not Applicable
		Family	$12,800	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	Not Covered
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	Not Covered
		Chiropractic Services	*$80 per visit	Not Covered
		Acupuncture	*$40 per visit	Not Covered
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	40%	Not Covered
Emergency Services				
		Emergency Department Visits	40%	In Network Benefit Applies
		Emergency Ambulance Transportation	40%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	40%	Not Covered
		Inpatient Hospitalization Facility Fees	40%	Not Covered
		Inpatient Physician/Surgeon Fees	40%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$40 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	40%	Not Covered
		Home Health	40%	Not Covered
Diagnostic Services				
		MRI and CT Scans	40%	Not Covered
		Laboratory	40%	Not Covered
		X-Ray	40%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	Not Covered
Inpatient Services	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$20	Not Covered
Tier 2 - Non-Preferred Generic	*$20	Not Covered
Tier 3 - Preferred Brand	*$40	Not Covered
Tier 4 - Non-Preferred Brand	$80	Not Covered
Tier 5 - Preferred Specialty	$350	Not Covered
Tier 6 - Non-Preferred Specialty	$350	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	40%	Not Covered
Maternity Inpatient	40%	Not Covered
Newborn Care	40%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	Not Covered
Abortion Procedure Facility Fee	40%	Not Covered
Abortion Procedure Physician Fee	40%	Not Covered
Durable Medical Equipment	40%	Not Covered

* Deductible does not apply

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2025 HMO 5000 Elite Silver CSR 87

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$500	Not Applicable
Embedded		Family	$1,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$3,000	Not Applicable
		Family	$6,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$20 per visit	Not Covered
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$40 per visit	Not Covered
		Chiropractic Services	*$40 per visit	Not Covered
		Acupuncture	*$20 per visit	Not Covered
		Urgent Care Visits	*$30 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	Not Covered
Emergency Services				
		Emergency Department Visits	30%	In Network Benefit Applies
		Emergency Ambulance Transportation	30%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	30%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	30%	Not Covered
		Inpatient Hospitalization Facility Fees	30%	Not Covered
		Inpatient Physician/Surgeon Fees	30%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$20 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	Not Covered
		Home Health	30%	Not Covered
Diagnostic Services				
		MRI and CT Scans	30%	Not Covered
		Laboratory	30%	Not Covered
		X-Ray	30%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$20 per visit	Not Covered
Inpatient Services	30%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$10	Not Covered
Tier 2 - Non-Preferred Generic	*$10	Not Covered
Tier 3 - Preferred Brand	*$20	Not Covered
Tier 4 - Non-Preferred Brand	$60	Not Covered
Tier 5 - Preferred Specialty	$250	Not Covered
Tier 6 - Non-Preferred Specialty	$250	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	30%	Not Covered
Maternity Inpatient	30%	Not Covered
Newborn Care	30%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	30%	Not Covered
Abortion Procedure Facility Fee	30%	Not Covered
Abortion Procedure Physician Fee	30%	Not Covered
Durable Medical Equipment	30%	Not Covered

* Deductible does not apply

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2025 HMO 5000 Elite Silver CSR 94

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$0	Not Applicable
Embedded		Family	$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,000	Not Applicable
		Family	$4,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Contract Year Maximum Benefits				
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event	
		Outpatient Rehabilitation Services	60 visits per condition per plan year	
		Habilitative Services	60 visits per condition per plan year	
		Chiropractic Services	25 visits per plan year.	
		Adult Vision Exam	Once every 12 months	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months	
		Pediatric Vision Materials	Once every 12 months.	
		Pediatric Dental Exam	Once every 6 months.	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$0 per visit	*Not Covered
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$10 per visit	*Not Covered
		Chiropractic Services	*$10 per visit	Not Covered
		Acupuncture	*$0 per visit	Not Covered
		Urgent Care Visits	*$5 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	*25%	*Not Covered
Emergency Services				
		Emergency Department Visits	*25%	In Network Benefit Applies
		Emergency Ambulance Transportation	*25%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	*25%	*Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	*25%	*Not Covered
		Inpatient Hospitalization Facility Fees	*25%	*Not Covered
		Inpatient Physician/Surgeon Fees	*25%	*Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$0 per visit	*Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	*25%	*Not Covered
		Home Health	*25%	*Not Covered
Diagnostic Services				
		MRI and CT Scans	*25%	*Not Covered
		Laboratory	*25%	*Not Covered
		X-Ray	*25%	*Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$0 per visit	*Not Covered
Inpatient Services	*25%	*Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	*Not Covered
Tier 2 - Non-Preferred Generic	*$0	*Not Covered
Tier 3 - Preferred Brand	*$15	*Not Covered
Tier 4 - Non-Preferred Brand	*$50	*Not Covered
Tier 5 - Preferred Specialty	*$150	*Not Covered
Tier 6 - Non-Preferred Specialty	*$150	*Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	*25%	*Not Covered
Maternity Inpatient	*25%	*Not Covered
Newborn Care	*25%	*Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	*Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	*25%	*Not Covered
Abortion Procedure Facility Fee	*25%	*Not Covered
Abortion Procedure Physician Fee	*25%	*Not Covered
Durable Medical Equipment	*25%	*Not Covered

* Deductible does not apply

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2025 POS 7250 Elite Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,250	$14,500
Embedded		Family	$14,500	$29,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$27,000
		Family	$18,400	$54,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	15%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	15%	50%
		Inpatient Hospitalization Facility Fees	15%	50%
		Inpatient Physician/Surgeon Fees	15%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	15%	50%
Emergency Services				
		Emergency Department Visits	15%	In Network Benefit Applies
		Emergency Ambulance Transportation	15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	15%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	15%	50%
		Home Health	15%	50%
Diagnostic Services				
		MRI and CT Scans	15%	50%
		Laboratory	*$100 per test	50%
		X-Ray	*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	15%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$30	50%
Tier 3 - Preferred Brand	*$60	50%
Tier 4 - Non-Preferred Brand	*$100	50%
Tier 5 - Preferred Specialty	*$300	50%
Tier 6 - Non-Preferred Specialty	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$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%	50%
Abortion Procedure Facility Fee	15%	50%
Abortion Procedure Physician Fee	15%	50%
Durable Medical Equipment	15%	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.

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2025 POS 7250 Elite Silver Ind CSR

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$7,250	$14,500
Embedded	Family	$0	$14,500	$29,000
	Pharmacy Individual	$0	Not Applicable	Not Applicable
	Family	$0	Not Applicable	Not Applicable
	Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$9,200	$27,000
	Family	$0	$18,400	$54,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$350	Not Applicable
	Family	$0	$700	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0 per visit	15%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	15%	50%
	Inpatient Hospitalization Facility Fees	$0 per stay	15%	50%
	Inpatient Physician/Surgeon Fees	$0 per procedure	15%	50%
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	*$20 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	*$40 per visit	50%
	Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	*$80 per visit	50%
	Chiropractic Services	$0 per visit	*$80 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	*$40 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	*$60 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	15%	50%
Emergency Services				
	Emergency Department Visits	$0 per visit	15%	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	15%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	15%	50%
	Home Health	$0	15%	50%

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	15%	50%
Laboratory	$0 per test	*$100 per test	50%
X-Ray	$0 per test	*$200 per test	50%
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	*$40 per visit	50%
Inpatient Services	$0 per stay	15%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic	$0	*$0	50%
Tier 2 - Non-Preferred Generic	$0	*$30	50%
Tier 3 - Preferred Brand	$0	*$60	50%
Tier 4 - Non-Preferred Brand	$0	*$100	50%
Tier 5 - Preferred Specialty	$0	*$300	50%
Tier 6 - Non-Preferred Specialty	$0	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	15%	50%
Maternity Inpatient	$0 per stay	15%	50%
Newborn Care	$0 per stay	15%	50%
Pediatric Services			
(members up to the age of 19 years old)			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	15%	50%
Abortion Procedure Facility Fee	$0	15%	50%
Abortion Procedure Physician Fee	$0	15%	50%
Durable Medical Equipment	$0	15%	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.

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2025 POS 7250 Elite Silver Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0
Embedded		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	$0 per procedure	$0 per procedure
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	$0 per test
Laboratory	$0 per test	$0 per test	$0 per test
X-Ray	$0 per test	$0 per test	$0 per test
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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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.

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2025 POS 7250 Elite Silver CSR 73

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$6,700	$13,400
Embedded		Family	$13,400	$26,800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,350	$25,900
		Family	$14,700	$51,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	15%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	15%	50%
		Inpatient Hospitalization Facility Fees	15%	50%
		Inpatient Physician/Surgeon Fees	15%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$40 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	50%
		Chiropractic Services	*$80 per visit	In Network Benefit Applies
		Acupuncture	*$40 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	15%	50%
Emergency Services				
		Emergency Department Visits	15%	In Network Benefit Applies
		Emergency Ambulance Transportation	15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	15%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	15%	50%
		Home Health	15%	50%
Diagnostic Services				
		MRI and CT Scans	15%	50%
		Laboratory	*$100 per test	50%
		X-Ray	*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	15%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$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%	50%
Abortion Procedure Facility Fee	15%	50%
Abortion Procedure Physician Fee	15%	50%
Durable Medical Equipment	15%	50%

* Deductible does not apply

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2025 POS 7250 Elite Silver CSR 87

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,700	$3,400
Embedded		Family	$3,400	$6,800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$2,400	$15,900
		Family	$4,800	$31,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	10%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	10%	50%
		Inpatient Hospitalization Facility Fees	10%	50%
		Inpatient Physician/Surgeon Fees	10%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$30 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$60 per visit	50%
		Chiropractic Services	*$60 per visit	In Network Benefit Applies
		Acupuncture	*$30 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	10%	50%
Emergency Services				
		Emergency Department Visits	10%	In Network Benefit Applies
		Emergency Ambulance Transportation	10%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	10%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	10%	50%
		Home Health	10%	50%
Diagnostic Services				
		MRI and CT Scans	10%	50%
		Laboratory	*$100 per test	50%
		X-Ray	*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	50%
Inpatient Services	10%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	10%	50%
Maternity Inpatient	10%	50%
Newborn Care	10%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	10%	50%
Abortion Procedure Facility Fee	10%	50%
Abortion Procedure Physician Fee	10%	50%
Durable Medical Equipment	10%	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.

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2025 POS 7250 Elite Silver CSR 94

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$200	$400
Embedded		Family	$400	$800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$800	$12,900
		Family	$1,600	$25,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	10%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	10%	50%
		Inpatient Hospitalization Facility Fees	10%	50%
		Inpatient Physician/Surgeon Fees	10%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$30 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$60 per visit	50%
		Chiropractic Services	*$60 per visit	In Network Benefit Applies
		Acupuncture	*$30 per visit	In Network Benefit Applies
		Urgent Care Visits	*$60 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	10%	50%
Emergency Services				
		Emergency Department Visits	10%	In Network Benefit Applies
		Emergency Ambulance Transportation	10%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	10%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	10%	50%
		Home Health	10%	50%
Diagnostic Services				
		MRI and CT Scans	10%	50%
		Laboratory	*$50 per test	50%
		X-Ray	*$50 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	50%
Inpatient Services	10%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	10%	50%
Maternity Inpatient	10%	50%
Newborn Care	10%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	10%	50%
Abortion Procedure Facility Fee	10%	50%
Abortion Procedure Physician Fee	10%	50%
Durable Medical Equipment	10%	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.

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2025 POS 6500 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$6,500	$13,000
Embedded		Family	$13,000	$26,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$25,500
		Family	$18,400	$51,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	25%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	25%	50%
		Inpatient Hospitalization Facility Fees	25%	50%
		Inpatient Physician/Surgeon Fees	25%	50%
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	25%	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	25%	50%
		Chiropractic Services	25%	In Network Benefit Applies
		Acupuncture	25%	In Network Benefit Applies
		Urgent Care Visits	*$80 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	25%	50%
Emergency Services				
		Emergency Department Visits	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	25%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	25%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	25%	50%
		Home Health	25%	50%
Diagnostic Services				
		MRI and CT Scans	25%	50%
		Laboratory	*$150 per test	50%
		X-Ray	*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	25%	50%
Inpatient Services	25%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$30	50%
Tier 3 - Preferred Brand	*$60	50%
Tier 4 - Non-Preferred Brand	*$100	50%
Tier 5 - Preferred Specialty	*$300	50%
Tier 6 - Non-Preferred Specialty	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	25%	50%
Maternity Inpatient	25%	50%
Newborn Care	25%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	50%
Abortion Procedure Facility Fee	25%	50%
Abortion Procedure Physician Fee	25%	50%
Durable Medical Equipment	25%	50%

* Deductible does not apply

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2025 POS 6500 Elite Bronze Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$6,500	$13,000
Embedded		Family	$0	$13,000	$26,000
	Pharmacy	Individual	$0	Not Applicable	Not Applicable
		Family	$0	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$9,200	$25,500
		Family	$0	$18,400	$51,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	25%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	25%	50%
		Inpatient Hospitalization Facility Fees	$0 per stay	25%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	25%	50%
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	25%	50%
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	25%	50%
		Chiropractic Services	$0 per visit	25%	In Network Benefit Applies
		Acupuncture	$0 per visit	25%	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	*$80 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	25%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	25%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	25%	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0	25%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	25%	50%
		Home Health	$0	25%	50%

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	25%	50%
Laboratory	$0 per test	*$150 per test	50%
X-Ray	$0 per test	*$200 per test	50%
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	25%	50%
Inpatient Services	$0 per stay	25%	50%
Virtual Behavioral Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$0	50%
Tier 2 - Non-Preferred Generic	$0	*$30	50%
Tier 3 - Preferred Brand	$0	*$60	50%
Tier 4 - Non-Preferred Brand	$0	*$100	50%
Tier 5 - Preferred Specialty	$0	*$300	50%
Tier 6 - Non-Preferred Specialty	$0	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	25%	50%
Maternity Inpatient	$0 per stay	25%	50%
Newborn Care	$0 per stay	25%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	25%	50%
Abortion Procedure Facility Fee	$0	25%	50%
Abortion Procedure Physician Fee	$0	25%	50%
Durable Medical Equipment	$0	25%	50%

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2025 POS 6500 Elite Bronze Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0
Embedded		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	$0 per procedure	$0 per procedure
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	$0 per test
Laboratory	$0 per test	$0 per test	$0 per test
X-Ray	$0 per test	$0 per test	$0 per test
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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2025 POS HSA 7350 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,350	$14,700
Embedded		Family	$14,700	$29,400
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,350	$27,200
		Family	$14,700	$54,400
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	0%	Not Covered
		Primary Care Physician Office Visits	0%	50%
		Virtual Primary Care Visit	0%	Not Covered
		Specialty Care Physician Office Visits	0%	50%
		Chiropractic Services	0%	In Network Benefit Applies
		Acupuncture	0%	In Network Benefit Applies
		Urgent Care Visits	0%	In Network Benefit Applies
		Virtual Urgent Care Visits	0%	Not Covered
		Allergy Treatment and Testing	0%	50%
Emergency Services				
		Emergency Department Visits	0%	In Network Benefit Applies
		Emergency Ambulance Transportation	0%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	0%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	0%	50%
		Inpatient Hospitalization Facility Fees	0%	50%
		Inpatient Physician/Surgeon Fees	0%	50%
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	0%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	0%	50%
		Home Health	0%	50%
Diagnostic Services				
		MRI and CT Scans	0%	50%
		Laboratory	0%	50%
		X-Ray	0%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	0%	50%
Inpatient Services	0%	50%
Virtual Mental Health Visits	0%	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	0%	50%
Tier 2 - Non-Preferred Generic	0%	50%
Tier 3 - Preferred Brand	0%	50%
Tier 4 - Non-Preferred Brand	0%	50%
Tier 5 - Preferred Specialty	0%	50%
Tier 6 - Non-Preferred Specialty	0%	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	0%	50%
Maternity Inpatient	0%	50%
Newborn Care	0%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	50%
Abortion Procedure Facility Fee	0%	50%
Abortion Procedure Physician Fee	0%	50%
Durable Medical Equipment	0%	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.

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2025 POS 7350 Elite Bronze Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$7,350	$14,700
Embedded		Family	$0	$14,700	$29,400
	Pharmacy	Individual	$0	Not Applicable	Not Applicable
		Family	$0	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$7,350	$27,200
		Family	$0	$14,700	$54,400
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	0%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	0%	50%
		Inpatient Hospitalization Facility Fees	$0 per stay	0%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	0%	50%
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	0%	Not Covered
		Primary Care Physician Office Visits	$0 per visit	0%	50%
		Virtual Primary Care Visit	$0 per visit	0%	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	0%	50%
		Chiropractic Services	$0 per visit	0%	In Network Benefit Applies
		Acupuncture	$0 per visit	0%	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	0%	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	0%	Not Covered
		Allergy Treatment and Testing	$0	0%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	0%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	0%	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	0%	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	0%	50%
		Home Health	$0	0%	50%

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	0%	50%
Laboratory	$0 per test	0%	50%
X-Ray	$0 per test	0%	50%
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	0%	50%
Inpatient Services	$0 per stay	0%	50%
Virtual Behavioral Health Visits	$0 per visit	0%	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	0%	50%
Tier 2 - Non-Preferred Generic	$0	0%	50%
Tier 3 - Preferred Brand	$0	0%	50%
Tier 4 - Non-Preferred Brand	$0	0%	50%
Tier 5 - Preferred Specialty	$0	0%	50%
Tier 6 - Non-Preferred Specialty	$0	0%	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	0%	50%
Maternity Inpatient	$0 per stay	0%	50%
Newborn Care	$0 per stay	0%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	0%	50%
Abortion Procedure Facility Fee	$0	0%	50%
Abortion Procedure Physician Fee	$0	0%	50%
Durable Medical Equipment	$0	0%	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.

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2025 POS 7350 Elite Bronze Ind CSR 0

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$0	$0	$0
Embedded	Family	$0	$0	$0
	Pharmacy Individual	Not Applicable	Not Applicable	Not Applicable
	Family	Not Applicable	Not Applicable	Not Applicable
	Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$0	$0	$0
	Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$0	$0	Not Applicable
	Family	$0	$0	Not Applicable
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
	Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	$0 per procedure	$0 per procedure
	Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
	Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
	Acupuncture Treatment	15 visits per plan year combined in-net and OON		
	Chiropractic Services	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		
	Pediatric Dental Exam	Once every 6 months combined in-net and OON		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	$0 per exam	$0 per exam	Not Covered
	Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
	Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
	Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
	Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
	Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
	Allergy Treatment and Testing	$0	$0	$0
Emergency Services				
	Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
	Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
	Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
	Home Health	$0	$0	$0

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	$0 per test
Laboratory	$0 per test	$0 per test	$0 per test
X-Ray	$0 per test	$0 per test	$0 per test
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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2025 POS 7500 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,500	$15,000
Embedded		Family	$15,000	$30,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$27,500
		Family	$18,400	$55,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Not Applicable
		Family	$700	Not Applicable
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	
		Acupuncture Treatment	15 visits per plan year combined in-net and OON	
		Chiropractic Services	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	
		Pediatric Dental Exam	Once every 6 months combined in-net and OON	
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$50 per visit	50%
		Virtual Primary Care Visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$100 per visit	50%
		Chiropractic Services	*$100 per visit	In Network Benefit Applies
		Acupuncture	*$50 per visit	In Network Benefit Applies
		Urgent Care Visits	*$75 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	Not Covered
		Allergy Treatment and Testing	50%	50%
Emergency Services				
		Emergency Department Visits	50%	In Network Benefit Applies
		Emergency Ambulance Transportation	50%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	50%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	50%	50%
		Inpatient Hospitalization Facility Fees	50%	50%
		Inpatient Physician/Surgeon Fees	50%	50%
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	*$50 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	50%	50%
		Home Health	50%	50%
Diagnostic Services				
		MRI and CT Scans	50%	50%
		Laboratory	50%	50%
		X-Ray	50%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$50 per visit	50%
Inpatient Services	50%	50%
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*		
Tier 1 - Preferred Generic	*$25	50%
Tier 2 - Non-Preferred Generic	*$25	50%
Tier 3 - Preferred Brand	$50	50%
Tier 4 - Non-Preferred Brand	$100	50%
Tier 5 - Preferred Specialty	$500	50%
Tier 6 - Non-Preferred Specialty	$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
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	50%	50%
Maternity Inpatient	50%	50%
Newborn Care	50%	50%
Pediatric Services *(members up to the age of 19 years old)*		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	50%
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*		
Wellness Care	*$0	50%
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*		
Other Covered Services	50%	50%
Abortion Procedure Facility Fee	50%	50%
Abortion Procedure Physician Fee	50%	50%
Durable Medical Equipment	50%	50%

* Deductible does not apply

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2025 POS 7500 Elite Bronze Ind CSR

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$7,500	$15,000
Embedded		Family	$0	$15,000	$30,000
	Pharmacy	Individual	$0	Not Applicable	Not Applicable
		Family	$0	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$9,200	$27,500
		Family	$0	$18,400	$55,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	Not Applicable
		Family	$0	$700	Not Applicable
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$50 per visit	50%
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$100 per visit	50%
		Chiropractic Services	$0 per visit	*$100 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	*$50 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	*$75 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	50%	50%
Emergency Services					
		Emergency Department Visits	$0 per visit	50%	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	50%	In Network Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0 per visit	50%	50%
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	50%	50%
		Inpatient Hospitalization Facility Fees	$0	50%	50%
		Inpatient Physician/Surgeon Fees	$0 per procedure	50%	50%
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	*$50 per visit	50%
		Inpatient Rehabilitation/Skilled Nursing Facility	$0	50%	50%
		Home Health	$0	50%	50%

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0	50%	50%
Laboratory	$0 per test	50%	50%
X-Ray	$0 per test	50%	50%
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	*$50 per visit	50%
Inpatient Services	$0	50%	50%
Virtual Mental Health Visits	$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	*$25	50%
Tier 2 - Non-Preferred Generic	$0	*$25	50%
Tier 3 - Preferred Brand	$0	$50	50%
Tier 4 - Non-Preferred Brand	$0	$100	50%
Tier 5 - Preferred Specialty	$0	$500	50%
Tier 6 - Non-Preferred Specialty	$0	$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	50%	50%
Maternity Inpatient	$0	50%	50%
Newborn Care	$0	50%	50%
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	50%	Not Covered
Major Dental Services	$0 per service	50%	Not Covered
Medically Necessary Orthodontia Services	$0 per service	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	50%
Pediatric Vision Materials	$0 per item	*$0 per item	In Network Benefit Applies
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	$0	50%	50%
Abortion Procedure Facility Fee	$0	50%	50%
Abortion Procedure Physician Fee	$0	50%	50%
Durable Medical Equipment	$0	50%	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.

2025 POS 7500 Elite Bronze Ind CSR 0

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0
Embedded		Family	$0	$0	$0
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0
		Family	$0	$0	$0
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	Not Applicable
		Family	$0	$0	Not Applicable
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0 per procedure	$0 per procedure	$0 per procedure
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay
		Inpatient Physician/Surgeon Fees	$0 per procedure	$0 per procedure	$0 per procedure
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		
		Acupuncture Treatment	15 visits per plan year combined in-net and OON		
		Chiropractic Services	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		
		Pediatric Dental Exam	Once every 6 months combined in-net and OON		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Virtual Primary Care Visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit
		Chiropractic Services	$0 per visit	$0 per visit	In Network Benefit Applies
		Acupuncture	$0 per visit	$0 per visit	In Network Benefit Applies
		Urgent Care Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0
Emergency Services					
		Emergency Department Visits	$0 per visit	$0 per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	In Network Benefit Applies
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay
		Home Health	$0	$0	$0

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	$0 per test	$0 per test	$0 per test
Laboratory	$0 per test	$0 per test	$0 per test
X-Ray	$0 per test	$0 per test	$0 per test
Mental Health/Substance Use Treatment			
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit
Inpatient Services	$0 per stay	$0 per stay	$0 per stay
Virtual Behavioral Health Visits	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	$0	$0	$0
Tier 2 - Non-Preferred Generic	$0	$0	$0
Tier 3 - Preferred Brand	$0	$0	$0
Tier 4 - Non-Preferred Brand	$0	$0	$0
Tier 5 - Preferred Specialty	$0	$0	$0
Tier 6 - Non-Preferred Specialty	$0	$0	$0
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	$0	$0	$0
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay
Newborn Care	$0 per stay	$0 per stay	$0 per stay
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam
Pediatric Vision Materials	$0 per item	$0 per item	In Network Benefit applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	$0	$0	$0
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	$0	$0	$0
Abortion Procedure Facility Fee	$0	$0	$0
Abortion Procedure Physician Fee	$0	$0	$0
Durable Medical Equipment	$0	$0	$0

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.

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2025 Simplete Memorial HMO Limited Network 2500 Gold

Member Benefits		Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical** Individual	$2,500	$5,000	Not Applicable
Embedded	Family	$5,000	$10,000	Not Applicable
	Pharmacy Individual	Not Applicable	Not Applicable	Not Applicable
	Family	Not Applicable	Not Applicable	Not Applicable
	Dental Per Member	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy** Individual	$6,000	$9,200	Not Applicable
	Family	$12,000	$18,400	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental** Individual	$350	$350	Not Applicable
	Family	$700	$700	Not Applicable
Contract Year Maximum Benefits				
	Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
	Outpatient Rehabilitation Services	60 visits per condition per plan year		
	Habilitative Services	60 visits per condition per plan year		
	Chiropractic Services	25 visits per plan year.		
	Adult Vision Exam	Once every 12 months		
	Acupuncture Treatment	15 visits per plan year		
	Pediatric Vision Exam	Once every 12 months		
	Pediatric Vision Materials	Once every 12 months.		
	Pediatric Dental Exam	Once every 6 months.		
	Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services				
	Vision Exam	*$20 per exam	*$20 per exam	Not Covered
	Primary Care Physician Office Visits	*$5 per visit	*$40 per visit	Not Covered
	Virtual Primary Care Visit	*$0 per visit	*$0 per visit	Not Covered
	Specialty Care Physician Office Visits	*$50 per visit	*$60 per visit	Not Covered
	Chiropractic Services	*$50 per visit	*$60 per visit	Not Covered
	Acupuncture	*$5 per visit	*$40 per visit	Not Covered
	Urgent Care Visits	*$40 per visit	*$40 per visit	Tier 2 Benefit Applies
	Virtual Urgent Care Visits	*$0 per visit	*$0 per visit	Not Covered
	Allergy Treatment and Testing	20%	40%	Not Covered
Emergency Services				
	Emergency Department Visits	20%	20%	Tier 2 Benefit Applies
	Emergency Ambulance Transportation	20%	20%	Tier 2 Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	20%	40%	Not Covered
	Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 20%	^$150 per procedure and Deductible then 40%	Not Covered
	Inpatient Hospitalization Facility Fees	20%	40%	Not Covered
	Inpatient Physician/Surgeon Fees	20%	40%	Not Covered
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	20%	40%	Not Covered
	Inpatient Rehabilitation/Skilled Nursing Facility	20%	40%	Not Covered
	Home Health	20%	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	20%	40%	Not Covered
Laboratory	*$20 per test	40%	Not Covered
X-Ray	*$20 per test	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$5 per visit	*$40 per visit	Not Covered
Inpatient Services	20%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$10	*$10	Not Covered
Tier 3 - Preferred Brand	*$40	*$40	Not Covered
Tier 4 - Non-Preferred Brand	*$80	*$80	Not Covered
Tier 5 - Preferred Specialty	*$250	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	*$400	*$400	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	20%	40%	Not Covered
Maternity Inpatient	20%	40%	Not Covered
Newborn Care	20%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0	*$0	Not Covered
Minor Dental Restorative	50%	50%	Not Covered
Major Dental Services	50%	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	*$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	20%	40%	Not Covered
Abortion Procedure Facility Fee	20%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 20%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	20%	40%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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.

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2025 Simplete Memorial HMO Limited Network 2500 Gold Ind CSR

Member Benefits			Member Responsibility Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of Network)
Plan Year Deductible Embedded	**Medical**	Individual	$0	$2,500	$5,000	Not Applicable
		Family	$0	$5,000	$10,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)						
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$6,000	$9,200	Not Applicable
		Family	$0	$12,000	$18,400	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	$350	Not Applicable
		Family	$0	$700	$700	Not Applicable
Contract Year Maximum Benefits						
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event			
		Outpatient Rehabilitation Services	60 visits per condition per plan year			
		Habilitative Services	60 visits per condition per plan year			
		Chiropractic Services	25 visits per plan year.			
		Adult Vision Exam	Once every 12 months			
		Acupuncture Treatment	15 visits per plan year			
		Pediatric Vision Exam	Once every 12 months			
		Pediatric Vision Materials	Once every 12 months.			
		Pediatric Dental Exam	Once every 6 months.			
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year			
Ambulatory Patient Services						
		Vision Exam	$0 per exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$5 per visit	*$40 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$50 per visit	*$60 per visit	Not Covered
		Chiropractic Services	$0 per visit	*$50 per visit	*$60 per visit	Not Covered
		Acupuncture	$0 per visit	*$5 per visit	*$40 per visit	Not Covered
		Urgent Care Visits	$0 per visit	*$40 per visit	*$40 per visit	*$40 per visit
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	20%	40%	Not Covered
Emergency Services						
		Emergency Department Visits	$0	20%	20%	20%
		Emergency Ambulance Transportation	$0	20%	20%	20%
Hospital Services						
		Outpatient Surgery/Procedures Facility Fee	$0	20%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	^$150 per procedure and Deductible then 20%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	$0	20%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	$0	20%	40%	Not Covered
Rehabilitative and Habilitative Services						
		Outpatient Rehabilitation Services (PT, OT, ST)	$0	20%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0	20%	40%	Not Covered
		Home Health	$0	20%	40%	Not Covered
Diagnostic Services						
		MRI and CT Scans	$0	20%	40%	Not Covered
		Laboratory	$0 per test	*$20 per test	40%	Not Covered
		X-Ray	$0 per test	*$20 per test	40%	Not Covered

Member Benefits	Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier2)	Non-Participating Out-of Network
Mental Health/Substance Use Treatment				
Outpatient Office Visits	$0 per visit	*$5 per visit	*$40 per visit	Not Covered
Inpatient Services	$0	20%	40%	Not Covered
Virtual Mental Health Visits	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs				
30 day supply				
Tier 1 - Preferred Generic	$0	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	*$10	*$10	Not Covered
Tier 3 - Preferred Brand	$0	*$40	*$40	Not Covered
Tier 4 - Non-Preferred Brand	$0	*$80	*$80	Not Covered
Tier 5 - Preferred Specialty	$0	*$250	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	$0	*$400	*$400	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug				
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	$0	20%	40%	Not Covered
Maternity Inpatient	$0	20%	40%	Not Covered
Newborn Care	$0	20%	40%	Not Covered
Pediatric Services				
(members up to the age of 19 years old)				
Pediatric Dental Exam	$0 per exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0	*0	*$0	Not Covered
Minor Dental Restorative	$0	50%	50%	Not Covered
Major Dental Services	$0	50%	50%	Not Covered
Medically Necessary Orthodontia Services	$0	*50%	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	*$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	*$0	Not Covered
Other Services				
Other services covered within your policy and not otherwise specified on this summary or on the SBC.				
Other Covered Services	$0	20%	40%	Not Covered
Abortion Procedure Facility Fee	$0	20%	40%	Not Covered
Abortion Procedure Physician Fee	$0	^$150 per procedure and Deductible then 20%	*$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	$0	20%	40%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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2025 Simplete Memorial HMO Limited Network 2500 Gold Ind CSR 0

Member Benefits			Member Responsibility Participating Indian Network)	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of Network
Plan Year Deductible	**Medical**	Individual	$0	$0	$0	Not Applicable
Embedded		Family	$0	$0	$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)						
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0	Not Applicable
		Family	$0	$0	$0	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	$0	Not Applicable
		Family	$0	$0	$0	Not Applicable
Contract Year Maximum Benefits						
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event			
		Outpatient Rehabilitation Services	60 visits per condition per plan year			
		Habilitative Services	60 visits per condition per plan year			
		Chiropractic Services	25 visits per plan year.			
		Adult Vision Exam	Once every 12 months			
		Acupuncture Treatment	15 visits per plan year			
		Pediatric Vision Exam	Once every 12 months			
		Pediatric Vision Materials	Once every 12 months.			
		Pediatric Dental Exam	Once every 6 months.			
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year			
Ambulatory Patient Services						
		Vision Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Chiropractic Services	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Acupuncture	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Urgent Care Visits	$0 per visit	$0 per visit	$0 per visit	$0 per visit
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0	Not Covered
Emergency Services						
		Emergency Department Visits	$0 per visit	$0 per visit	$0 per visit	$0 per visit
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	$0 per transport	$0 per transport
Hospital Services						
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0	Not Covered
		Inpatient Hospitalization Facility Fees	$0 per stay	$0 per stay	$0 per stay	Not Covered
		Inpatient Physician/Surgeon Fees	$0	$0	$0	Not Covered
Rehabilitative and Habilitative Services						
		Outpatient Rehabilitation Services (PT, OT, ST)	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0 per stay	$0 per stay	$0 per stay	Not Covered
		Home Health	$0	$0	$0	Not Covered
Diagnostic Services						
		MRI and CT Scans	$0 per test	$0 per test	$0 per test	Not Covered
		Laboratory	$0 per test	$0 per test	$0 per test	Not Covered
		X-Ray	$0 per test	$0 per test	$0 per test	Not Covered

Member Benefits	Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating Out-of Network
Mental Health/Substance Use Treatment				
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
Inpatient Services	$0	$0	$0	Not Covered
Virtual Mental Health Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
Prescription Drugs *30 day supply*				
Tier 1 - Preferred Generic	$0	$0	$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	$0	$0	Not Covered
Tier 3 - Preferred Brand	$0	$0	$0	Not Covered
Tier 4 - Non-Preferred Brand	$0	$0	$0	Not Covered
Tier 5 - Preferred Specialty	$0	$0	$0	Not Covered
Tier 6 - Non-Preferred Specialty	$0	$0	$0	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug				
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	$0	$0	$0	Not Covered
Maternity Inpatient	$0 per stay	$0 per stay	$0 per stay	Not Covered
Newborn Care	$0	$0	$0	Not Covered
Pediatric Services *(members up to the age of 19 years old)*				
Pediatric Dental Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0	$0	$0	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	$0 per item	$0 per item	Not Covered
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*				
Wellness Care	$0	$0	$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*				
Other Covered Services	$0	$0	$0	Not Covered
Abortion Procedure Facility Fee	$0	$0	$0	Not Covered
Abortion Procedure Physician Fee	$0	$0	$0	Not Covered
Durable Medical Equipment	$0	$0	$0	Not Covered

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.

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2025 Simplete Memorial HMO Limited Network 3500 Silver

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$3,500	$7,000	Not Applicable
Embedded		Family	$7,000	$14,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,000	$9,200	Not Applicable
		Family	$14,000	$18,400	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	$350	Not Applicable
		Family	$700	$700	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$10 per visit	40%	Not Covered
		Virtual Primary Care Visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	40%	Not Covered
		Chiropractic Services	*$80 per visit	40%	Not Covered
		Acupuncture	*$10 per visit	40%	Not Covered
		Urgent Care Visits	*$80 per visit	*$80 per visit	Tier 2 Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	40%	Not Covered
Emergency Services					
		Emergency Department Visits	^$500 per visit and Deductible then 30%	^$500 per visit and Deductible then 30%	Tier 2 Benefit Applies
		Emergency Ambulance Transportation	30%	30%	Tier 2 Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	30%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	30%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	30%	40%	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	30%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	40%	Not Covered
		Home Health	30%	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	30%	40%	Not Covered
Laboratory	30%	40%	Not Covered
X-Ray	30%	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$10 per visit	40%	Not Covered
Inpatient Services	30%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	*$500	*$500	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	30%	40%	Not Covered
Maternity Inpatient	30%	40%	Not Covered
Newborn Care	30%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	50%	50%	Not Covered
Major Dental Services	50%	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	*$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	30%	40%	Not Covered
Abortion Procedure Facility Fee	30%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	30%	40%	Not Covered

* Deductible does not apply
^ Copay applies before the Deductible
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.

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2025 Simplete Memorial HMO Limited Network 3500 Silver Ind CSR

Member Benefits			Member Responsibility Participating Indian Network)	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of Network
Plan Year Deductible	**Medical**	Individual	$0	$3,500	$7,000	Not Applicable
Embedded		Family	$0	$7,000	$14,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)						
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$7,000	$9,200	Not Applicable
		Family	$0	$14,000	$18,400	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$350	$350	Not Applicable
		Family	$0	$700	$700	Not Applicable
Contract Year Maximum Benefits						
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event			
		Outpatient Rehabilitation Services	60 visits per condition per plan year			
		Habilitative Services	60 visits per condition per plan year			
		Chiropractic Services	25 visits per plan year.			
		Adult Vision Exam	Once every 12 months			
		Acupuncture Treatment	15 visits per plan year			
		Pediatric Vision Exam	Once every 12 months			
		Pediatric Vision Materials	Once every 12 months.			
		Pediatric Dental Exam	Once every 6 months.			
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year			
Ambulatory Patient Services						
		Vision Exam	$0 per exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	*$10 per visit	40%	Not Covered
		Virtual Primary Care Visit	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	*$80 per visit	40%	Not Covered
		Chiropractic Services	$0 per visit	*$80 per visit	40%	Not Covered
		Acupuncture	$0 per visit	*$10 per visit	40%	Not Covered
		Urgent Care Visits	$0 per visit	*$80 per visit	*$80 per visit	*$80 per visit
		Virtual Urgent Care Visits	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	30%	40%	Not Covered
Emergency Services						
		Emergency Department Visits	$0 per visit	^$500 per visit and Deductible then 30%	^$500 per visit and Deductible then 30%	Tier 2 Benefit Applies
		Emergency Ambulance Transportation	$0	30%	30%	30%
Hospital Services						
		Outpatient Surgery/Procedures Facility Fee	$0	30%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	$0	30%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	$0	30%	40%	Not Covered
Rehabilitative and Habilitative Services						
		Outpatient Rehabilitation Services (PT, OT, ST)	$0	30%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0	30%	40%	Not Covered
		Home Health	$0	30%	40%	Not Covered
Diagnostic Services						
		MRI and CT Scans	$0	30%	40%	Not Covered
		Laboratory	$0	30%	40%	Not Covered
		X-Ray	$0	30%	40%	Not Covered

Member Benefits	Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating Out-of Network
Mental Health/Substance Use Treatment				
Outpatient Office Visits	$0 per visit	*$10 per visit	40%	Not Covered
Inpatient Services	$0	30%	40%	Not Covered
Virtual Mental Health Visits	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*				
Tier 1 - Preferred Generic	$0	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	$0	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	$0	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	$0	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	$0	*$500	*$500	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug				
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	$0	30%	40%	Not Covered
Maternity Inpatient	$0	30%	40%	Not Covered
Newborn Care	$0	30%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*				
Pediatric Dental Exam	$0 per exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	*$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	50%	50%	50%	Not Covered
Major Dental Services	$0	50%	50%	Not Covered
Medically Necessary Orthodontia Services	$0	*50%	*50%	Not Covered
Pediatric Vision Exam	$0 per exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	*$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	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*				
Other Covered Services	$0	30%	40%	Not Covered
Abortion Procedure Facility Fee	$0	30%	40%	Not Covered
Abortion Procedure Physician Fee	$0	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	$0	30%	40%	Not Covered

* Deductible does not apply
^ Copay applies before the Deductible
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.

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2025 Simplete Memorial HMO Limited Network 3500 Silver Ind CSR 0

Member Benefits			Member Responsibility Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-Of Network)
Plan Year Deductible	**Medical**	Individual	$0	$0	$0	Not Applicable
Embedded		Family	$0	$0	$0	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$0	$0	$0	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)						
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$0	$0	$0	Not Applicable
		Family	$0	$0	$0	Not Appicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$0	$0	$0	Not Applicable
		Family	$0	$0	$0	Not Applicable
Contract Year Maximum Benefits						
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event			
		Outpatient Rehabilitation Services	60 visits per condition per plan year			
		Habilitative Services	60 visits per condition per plan year			
		Chiropractic Services	25 visits per plan year.			
		Adult Vision Exam	Once every 12 months			
		Acupuncture Treatment	15 visits per plan year			
		Pediatric Vision Exam	Once every 12 months			
		Pediatric Vision Materials	Once every 12 months.			
		Pediatric Dental Exam	Once every 6 months.			
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year			
Ambulatory Patient Services						
		Vision Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
		Primary Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Virtual Primary Care Visit	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Specialty Care Physician Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Chiropractic Services	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Acupuncture	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Urgent Care Visits	$0 per visit	$0 per visit	$0 per visit	$0 per visit
		Virtual Urgent Care Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
		Allergy Treatment and Testing	$0	$0	$0	Not Covered
Emergency Services						
		Emergency Department Visits	$0 per visit	$0 per visit	$0 per visit	$0 per visit
		Emergency Ambulance Transportation	$0 per transport	$0 per transport	$0 per transport	$0 per trans.
Hospital Services						
		Outpatient Surgery/Procedures Facility Fee	$0	$0	$0	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	$0	$0	$0	Not Covered
		Inpatient Hospitalization Facility Fees	$0	$0	$0	Not Covered
		Inpatient Physician/Surgeon Fees	$0	$0	$0	Not Covered
Rehabilitative and Habilitative Services						
		Outpatient Rehabilitation Services (PT, OT, ST)	$0	$0	$0	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	$0	$0	$0	Not Covered
		Home Health	$0	$0	$0	Not Covered
Diagnostic Services						
		MRI and CT Scans	$0 per test	$0 per test	$0 per test	Not Covered
		Laboratory	$0 per test	$0 per test	$0 per test	Not Covered
		X-Ray	$0 per test	$0 per test	$0 per test	Not Covered

Member Benefits	Participating Indian Network	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating Out-of Network
Mental Health/Substance Use Treatment				
Outpatient Office Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
Inpatient Services	$0	$0	$0	Not Covered
Virtual Mental Health Visits	$0 per visit	$0 per visit	$0 per visit	Not Covered
Prescription Drugs				
30 day supply				
Tier 1 - Preferred Generic	$0	$0	$0	Not Covered
Tier 2 - Non-Preferred Generic	$0	$0	$0	Not Covered
Tier 3 - Preferred Brand	$0	$0	$0	Not Covered
Tier 4 - Non-Preferred Brand	$0	$0	$0	Not Covered
Tier 5 - Preferred Specialty	$0	$0	$0	Not Covered
Tier 6 - Non-Preferred Specialty	$0	$0	$0	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug				
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	$0	$0	$0	Not Covered
Maternity Inpatient	$0	$0	$0	Not Covered
Newborn Care	$0	$0	$0	Not Covered
Pediatric Services				
(members up to the age of 19 years old)				
Pediatric Dental Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
Preventive Dental Services	$0 per visit	$0 per visit	$0 per visit	Not Covered
Minor Dental Restorative	$0 per service	$0 per service	$0 per service	Not Covered
Major Dental Services	$0 per service	$0 per service	$0 per service	Not Covered
Medically Necessary Orthodontia Services	$0 per service	$0 per service	$0 per service	Not Covered
Pediatric Vision Exam	$0 per exam	$0 per exam	$0 per exam	Not Covered
Pediatric Vision Materials	$0 per item	$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	$0	Not Covered
Other Services				
Other services covered within your policy and not otherwise specified on this summary or on the SBC.				
Other Covered Services	$0	$0	$0	Not Covered
Abortion Procedure Facility Fee	$0	$0	$0	Not Covered
Abortion Procedure Physician Fee	$0	$0	$0	Not Covered
Durable Medical Equipment	$0	$0	$0	Not Covered

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2025 Simplete Memorial HMO Limited Network 3500 Silver CSR 73

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$3,400	$5,500	Not Applicable
Embedded		Family	$6,800	$11,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$5,900	$7,000	Not Applicable
		Family	$11,800	$14,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	$350	Not Applicable
		Family	$700	$700	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$10 per visit	40%	Not Covered
		Virtual Primary Care Visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	40%	Not Covered
		Chiropractic Services	*$80 per visit	40%	Not Covered
		Acupuncture	*$10 per visit	40%	Not Covered
		Urgent Care Visits	*$80 per visit	*$80 per visit	Tier 2 Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	40%	Not Covered
Emergency Services					
		Emergency Department Visits	^$500 per visit and Deductible then 30%	^$500 per visit and Deductible then 30%	Tier 2 Benefit Applies
		Emergency Ambulance Transportation	30%	30%	Tier 2 Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	30%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	30%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	30%	40%	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	30%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	40%	Not Covered
		Home Health	30%	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	30%	40%	Not Covered
Laboratory	30%	40%	Not Covered
X-Ray	30%	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$10 per visit	40%	Not Covered
Inpatient Services	30%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	*$500	*$500	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	30%	40%	Not Covered
Maternity Inpatient	30%	40%	Not Covered
Newborn Care	30%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	50%	50%	Not Covered
Major Dental Services	50%	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	*$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	30%	40%	Not Covered
Abortion Procedure Facility Fee	30%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	30%	40%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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2025 Simplete Memorial HMO Limited Network 3500 Silver CSR 87

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$1,000	$2,000	Not Applicable
Embedded		Family	$2,000	$4,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$1,800	$2,500	Not Applicable
		Family	$3,600	$5,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	$350	Not Applicable
		Family	$700	$700	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$10 per visit	40%	Not Covered
		Virtual Primary Care Visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	40%	Not Covered
		Chiropractic Services	*$80 per visit	40%	Not Covered
		Acupuncture	*$10 per visit	40%	Not Covered
		Urgent Care Visits	*$80 per visit	*$80 per visit	Tier 2 Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	40%	Not Covered
Emergency Services					
		Emergency Department Visits	^$500 per visit and Deductible then 30%	^$500 per visit and Deductible then 30%	Tier 2 Benefit Applies
		Emergency Ambulance Transportation	30%	30%	Tier 2 Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	30%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	30%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	30%	40%	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	30%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	40%	Not Covered
		Home Health	30%	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	30%	40%	Not Covered
Laboratory	30%	40%	Not Covered
X-Ray	30%	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$10 per visit	40%	Not Covered
Inpatient Services	30%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	*$500	*$500	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
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	30%	40%	Not Covered
Maternity Inpatient	30%	40%	Not Covered
Newborn Care	30%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	50%	50%	Not Covered
Major Dental Services	50%	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	*$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	30%	40%	Not Covered
Abortion Procedure Facility Fee	30%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	30%	40%	Not Covered

* Deductible does not apply
^ Copay applies before the Deductible
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.

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2025 Simplete Memorial HMO Limited Network 3500 Silver CSR 94

Member Benefits			Member Responsibility Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Plan Year Deductible	**Medical**	Individual	$300	$600	Not Applicable
Embedded		Family	$600	$1,200	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable	Not Applicable
		Dental Per Member	$120	$120	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)					
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$600	$900	Not Applicable
		Family	$1,200	$1,800	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	$350	Not Applicable
		Family	$700	$700	Not Applicable
Contract Year Maximum Benefits					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per condition per plan year		
		Habilitative Services	60 visits per condition per plan year		
		Chiropractic Services	25 visits per plan year.		
		Adult Vision Exam	Once every 12 months		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Exam	Once every 12 months		
		Pediatric Vision Materials	Once every 12 months.		
		Pediatric Dental Exam	Once every 6 months.		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
Ambulatory Patient Services					
		Vision Exam	*$20 per exam	*$20 per exam	Not Covered
		Primary Care Physician Office Visits	*$10 per visit	40%	Not Covered
		Virtual Primary Care Visit	*$0 per visit	*$0 per visit	Not Covered
		Specialty Care Physician Office Visits	*$80 per visit	40%	Not Covered
		Chiropractic Services	*$80 per visit	40%	Not Covered
		Acupuncture	*$10 per visit	40%	Not Covered
		Urgent Care Visits	*$80 per visit	*$80 per visit	Tier 2 Benefit Applies
		Virtual Urgent Care Visits	*$0 per visit	*$0 per visit	Not Covered
		Allergy Treatment and Testing	30%	40%	Not Covered
Emergency Services					
		Emergency Department Visits	^$500 per visit and Deductible then 30%	^$500 per visit and Deductible then 30%	Tier 2 Benefit Applies
		Emergency Ambulance Transportation	30%	30%	Tier 2 Benefit Applies
Hospital Services					
		Outpatient Surgery/Procedures Facility Fee	30%	40%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
		Inpatient Hospitalization Facility Fees	30%	40%	Not Covered
		Inpatient Physician/Surgeon Fees	30%	40%	Not Covered
Rehabilitative and Habilitative Services					
		Outpatient Rehabilitation Services (PT, OT, ST)	30%	40%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	30%	40%	Not Covered
		Home Health	30%	40%	Not Covered

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Diagnostic Services			
MRI and CT Scans	30%	40%	Not Covered
Laboratory	30%	40%	Not Covered
X-Ray	30%	40%	Not Covered
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$10 per visit	40%	Not Covered
Inpatient Services	30%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs *30 day supply*			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	*$500	*$500	Not Covered
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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	30%	40%	Not Covered
Maternity Inpatient	30%	40%	Not Covered
Newborn Care	30%	40%	Not Covered
Pediatric Services *(members up to the age of 19 years old)*			
Pediatric Dental Exam	*$0 per exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	*$0 per visit	Not Covered
Minor Dental Restorative	50%	50%	Not Covered
Major Dental Services	50%	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services *Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*			
Wellness Care	*$0	*$0	Not Covered
Other Services *Other services covered within your policy and not otherwise specified on this summary or on the SBC.*			
Other Covered Services	30%	40%	Not Covered
Abortion Procedure Facility Fee	30%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	30%	40%	Not Covered

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