

Illinois

2025 Small Group Plans



Plans to Fit Your Needs

The plans in this booklet are direct plans. For more information, please call Health Alliance™ at (800) 851-3379, Ext. 28151, or visit HealthAlliance.org.

A small group in Illinois is defined as 1 – 50 total employees.





World-Class Coverage Close to Home

Health Alliance is the largest health insurer based in downstate Illinois, with member-focused health plans in three states – Illinois, Iowa and Indiana. Our nearly 700 employees serve more than 205,000 members across all three states.

We deliver access to reliable, high-quality healthcare. This means connecting you and your employees with the right care at the right time for the right cost.

As a community-based health insurer, we offer dedicated, local support that's made for you and your employees. And by partnering with local health systems, we work with doctors you know and trust.

Local and Accessible Service

We aren't just another insurance option. We're accessible to you and your employees when you need us. We have nearby offices in Champaign, IL, and provide you with a personal business consultant for support.

Sales and Retention Department
Health Alliance
3310 Fields South Dr.
Champaign, IL 61822
(800) 851-3379, Ext. 28151
SalesAdmin@HealthAlliance.org



It's our goal to provide the best options to improve the value of care and services your employees receive – total care coordination close to home.



Life is unpredictable, and sickness or injury is bound to happen. That's why your employees deserve coverage made for whatever life sends their way, and resources designed to keep them healthy.

Health Alliance small group plans offer the complete package made for you and your employees:

- Strong provider networks with doctors your employees know and trust.
- Fast and helpful answers from our top-notch customer service reps.
- Access your coverage anytime, anywhere with your secure Hally® account on the MyChart app or at hally.com.
- Wellness programs that help your employees take charge of their health.
- Pharmacy discount programs.
- Additional dental and vision coverage is available.

At Health Alliance, we keep healthcare decisions where they belong — between patients and their doctors. We understand our role as the insurance provider and let doctors provide the care.

HMO Plans



Structure

- Only care received within the HMO network is covered.
- Out-of-network coverage is available in emergencies or when prior authorization is given.
- Members choose a primary care provider (PCP) to coordinate all medical care.
- For specialty care, a PCP gives a referral to an in-network specialist.
- Women can select a Woman's Principal Healthcare Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

A PCP gives attention to members' personalized, overall health and serves as their healthcare partner.



2025 HMO 2000 Gold

Member Benefits	Member Responsibility			
			Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible Embedded	Medical	Individual	\$2,000	Not Applicable
		Family	\$4,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,900	Not Applicable
		Family	\$13,800	Not Applicable
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Not Applicable
		Family	Refer to Delta Dental Materials	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.	
		Acupuncture Treatment	15 visits per plan year	
		Adult Vision Exam	Once every 12 months.	
		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	*\$25 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	*\$25 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	10%	Not Covered
Emergency Services				
		Emergency Department Visits	^\$400 and Deductible then 10% per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	10%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	10%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^\$150 per procedure and Deductible then 10%	Not Covered
		Inpatient Hospitalization Facility Fees	10%	Not Covered
		Inpatient Physician/Surgeon Fees	10%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	10%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	10%	Not Covered
		Home Health	10%	Not Covered
Diagnostic Services				
		MRI and CT Scans	10%	Not Covered
		Laboratory	10%	Not Covered
		X-Ray	10%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*\$25 per visit	Not Covered
Inpatient Services	10%	Not Covered
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	Not Covered
Tier 2 - Non-Preferred Generic	*\$10	Not Covered
Tier 3 - Preferred Brand	*\$40	Not Covered
Tier 4 - Non-Preferred Brand	*\$80	Not Covered
Tier 5 - Preferred Specialty	*\$250	Not Covered
Tier 6 - Non-Preferred Specialty	*\$400	Not Covered
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	10%	Not Covered
Maternity Inpatient	10%	Not Covered
Newborn Care	10%	Not Covered
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Not Covered
Preventive Dental Services	Refer to Delta Dental Materials	Not Covered
Minor Dental Restorative	Refer to Delta Dental Materials	Not Covered
Major Dental Services	Refer to Delta Dental Materials	Not Covered
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Not Covered
Pediatric Vision Exam	*\$0 per exam	Not Covered
Pediatric Vision Materials	*\$0 per item	Not Covered
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	Not Covered
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	10%	Not Covered
Abortion Procedure Facility Fee	10%	Not Covered
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 10%	Not Covered
Durable Medical Equipment	10%	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.

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.



2025 HMO 6500 Silver

Member Benefits	Member Responsibility			
			Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible Embedded	Medical	Individual	\$6,500	Not Applicable
		Family	\$13,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Not Applicable
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$9,200	Not Applicable
		Family	\$18,400	Not Applicable
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Not Applicable
		Family	Refer to Delta Dental Materials	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.	
	Acupuncture Treatment		15 visits per plan year	
	Adult Vision Exam		Once every 12 months.	
	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		*\$50 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		*\$50 per visit	Not Covered
	Urgent Care Visits		*\$70 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		^\$400 and Deductible then 30% per visit	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		^\$200 per procedure and Deductible then 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)		30%	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	*\$50 per visit	Not Covered
Inpatient Services	30%	Not Covered
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	Not Covered
Tier 2 - Non-Preferred Generic	*\$15	Not Covered
Tier 3 - Preferred Brand	*\$50	Not Covered
Tier 4 - Non-Preferred Brand	*\$90	Not Covered
Tier 5 - Preferred Specialty	*\$300	Not Covered
Tier 6 - Non-Preferred Specialty	*\$500	Not Covered
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	30%	Not Covered
Maternity Inpatient	30%	Not Covered
Newborn Care	30%	Not Covered
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Not Covered
Preventive Dental Services	Refer to Delta Dental Materials	Not Covered
Minor Dental Restorative	Refer to Delta Dental Materials	Not Covered
Major Dental Services	Refer to Delta Dental Materials	Not Covered
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Not Covered
Pediatric Vision Exam	*\$0 per exam	Not Covered
Pediatric Vision Materials	*\$0 per item	Not Covered
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	Not Covered
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	30%	Not Covered
Abortion Procedure Facility Fee	30%	Not Covered
Abortion Procedure Physician Fee	^\$200 per procedure and Deductible then 30%	Not Covered
Durable Medical Equipment	30%	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.

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.

POS Plans



Structure

- Coverage is determined at the point of service (POS), depending on the provider chosen. When choosing a Health Alliance in-network provider, HMO-style benefits apply. When choosing an out-of-network provider, your costs may be higher, except in emergencies or when prior authorization is given.
- When members use participating providers, they receive the highest level of benefits and the lowest cost-share. Members using a nonparticipating provider may have a higher cost-share, unless costs are related to emergency services or the member received prior authorization.

- In-network specialty care without a referral is covered at the in-network cost-share. Members receive a lower benefit level when they use a nonparticipating provider.
- Members are responsible for any services utilizing extended network providers or requiring prior authorization.

Considerations

- Staying in network for care is vital to the cost effectiveness of your POS plan. Our network is extensive and features premier providers.
- A primary care provider (PCP) gives attention to members' personalized, overall health and serves as their healthcare partner.



2025 POS 500 Platinum

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$500	\$1,000
		Family	\$1,000	\$2,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials	
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$3,000	\$6,000
		Family	\$6,000	\$12,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$45 per visit	50%
	Chiropractic Services		*\$45 per visit	In Network Benefit Applies
	Acupuncture		*\$20 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		20%	50%
Emergency Services				
	Emergency Department Visits		20%	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	20%	50%
Durable Medical Equipment	20%	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 1000 Platinum

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$1,000	\$2,000
		Family	\$2,000	\$4,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials	
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$2,500	\$14,500
		Family	\$5,000	\$29,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$45 per visit	50%
	Chiropractic Services		*\$45 per visit	In Network Benefit Applies
	Acupuncture		*\$20 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		20%	50%
Emergency Services				
	Emergency Department Visits		20%	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	20%	50%
Durable Medical Equipment	20%	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 1000 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$1,000	\$2,000
		Family	\$2,000	\$4,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials	
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,500	\$13,000
		Family	\$13,000	\$26,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		20%	50%
Emergency Services				
	Emergency Department Visits		20%	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$150 per procedure and Deductible then 20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<p><i>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</i></p>		
Maternity		
<p><i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i></p>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<p><i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i></p>		
Wellness Care	*\$0	50%
Other Services		
<p><i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i></p>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 20%	50%
Durable Medical Equipment	20%	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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2025 POS 1500 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$1,500	\$3,000
		Family	\$3,000	\$6,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,750	\$15,500
		Family	\$13,500	\$31,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		20%	50%
Emergency Services				
	Emergency Department Visits		20%	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$150 per procedure and Deductible then 20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs <i>30 day supply</i>		
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%
<i>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</i>		
Maternity <i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services <i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services <i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services <i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 20%	50%
Durable Medical Equipment	20%	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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2025 POS 2000 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$2,000	\$4,000
		Family	\$4,000	\$8,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,000	\$16,500
		Family	\$12,000	\$33,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		20%	50%
Emergency Services				
	Emergency Department Visits		^\$400 and Deductible then 20% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$150 per procedure and Deductible then 20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 20%	50%
Durable Medical Equipment	20%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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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 2500 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$2,500	\$5,000
		Family	\$5,000	\$10,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,000	\$17,500
		Family	\$12,000	\$35,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		20%	50%
Emergency Services				
	Emergency Department Visits		^\$400 and Deductible then 20% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$150 per procedure and Deductible then 20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<p><i>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</i></p>		
Maternity		
<p><i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i></p>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<p><i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i></p>		
Wellness Care	*\$0	50%
Other Services		
<p><i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i></p>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 20%	50%
Durable Medical Equipment	20%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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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 3000 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$3,000	\$6,000
		Family	\$6,000	\$12,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,500	\$18,500
		Family	\$13,000	\$37,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		^\$400 and Deductible then 10% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		10%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		10%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$150 per procedure and Deductible then 10%	50%
	Inpatient Hospitalization Facility Fees		10%	50%
	Inpatient Physician/Surgeon Fees		10%	50%
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		10%	50%
	X-Ray		10%	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	10%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	10%	50%
Maternity Inpatient	10%	50%
Newborn Care	10%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	10%	50%
Abortion Procedure Facility Fee	10%	50%
Abortion Procedure Physician Fee	^\$150 per procedure and Deductible then 10%	50%
Durable Medical Equipment	10%	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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2025 POS 3500 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$3,500	\$7,000
		Family	\$7,000	\$14,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$7,000	\$19,500
		Family	\$14,000	\$39,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$60 per visit	50%
	Chiropractic Services		*\$60 per visit	In Network Benefit Applies
	Acupuncture		*\$25 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		20%	50%
Emergency Services				
	Emergency Department Visits		^\$400 and Deductible then 20% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		20%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		20%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		20%	50%
	Inpatient Hospitalization Facility Fees		20%	50%
	Inpatient Physician/Surgeon Fees		20%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		20%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		20%	50%
	Home Health		20%	50%
Diagnostic Services				
	MRI and CT Scans		20%	50%
	Laboratory		20%	50%
	X-Ray		20%	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	20%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
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%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	20%	50%
Durable Medical Equipment	20%	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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2025 POS 3800 Silver

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$3,800	\$7,600
		Family	\$7,600	\$15,200
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$9,200	\$20,100
		Family	\$18,400	\$40,200
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$70 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		^\$400 and Deductible then 40% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		40%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		40%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$200 per procedure, and deductible then 40%	50%
	Inpatient Hospitalization Facility Fees		40%	50%
	Inpatient Physician/Surgeon Fees		40%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		40%	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 Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$15	50%
Tier 3 - Preferred Brand	*\$50	50%
Tier 4 - Non-Preferred Brand	*\$90	50%
Tier 5 - Preferred Specialty	*\$300	50%
Tier 6 - Non-Preferred Specialty	*\$500	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	^\$200 per procedure and Deductible then 40%	50%
Durable Medical Equipment	40%	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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2025 POS 5500 Silver

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$5,500	\$11,000
		Family	\$11,000	\$22,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$9,200	\$23,500
		Family	\$18,400	\$47,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		*\$80 per visit	50%
	Chiropractic Services		*\$80 per visit	In Network Benefit Applies
	Acupuncture		*\$50 per visit	In Network Benefit Applies
	Urgent Care Visits		*\$70 per visit	In Network Benefit Applies
	Virtual Urgent Care Visits		*\$0 per visit	Not Covered
	Allergy Treatment and Testing		35%	50%
Emergency Services				
	Emergency Department Visits		^\$400 and Deductible then 35% per visit	In Network Benefit Applies
	Emergency Ambulance Transportation		35%	In Network Benefit Applies
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee		35%	50%
	Outpatient Surgery/Procedures Physician/Surgeon Services		^\$200 and Deductible then 35% per visit	50%
	Inpatient Hospitalization Facility Fees		35%	50%
	Inpatient Physician/Surgeon Fees		35%	50%
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)		35%	50%
	Inpatient Rehabilitation/Skilled Nursing Facility		35%	50%
	Home Health		35%	50%
Diagnostic Services				
	MRI and CT Scans		35%	50%
	Laboratory		35%	50%
	X-Ray		35%	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	35%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$15	50%
Tier 3 - Preferred Brand	*\$50	50%
Tier 4 - Non-Preferred Brand	*\$90	50%
Tier 5 - Preferred Specialty	*\$300	50%
Tier 6 - Non-Preferred Specialty	*\$500	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	35%	50%
Maternity Inpatient	35%	50%
Newborn Care	35%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	35%	50%
Abortion Procedure Facility Fee	35%	50%
Abortion Procedure Physician Fee	^\$200 and Deductible then 35% per visit	50%
Durable Medical Equipment	35%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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2025 POS 7500 Bronze

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$7,500	\$15,000
		Family	\$15,000	\$30,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$9,200	\$27,500
		Family	\$18,400	\$55,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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%	50%
	Virtual Primary Care Visit		*\$0 per visit	Not Covered
	Specialty Care Physician Office Visits		50%	50%
	Chiropractic Services		50%	In Network Benefit Applies
	Acupuncture		50%	In Network Benefit Applies
	Urgent Care Visits		50%	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%	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%	50%
Inpatient Services	50%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$15	50%
Tier 3 - Preferred Brand	*\$50	50%
Tier 4 - Non-Preferred Brand	*\$90	50%
Tier 5 - Preferred Specialty	*\$300	50%
Tier 6 - Non-Preferred Specialty	*\$500	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	50%	50%
Maternity Inpatient	50%	50%
Newborn Care	50%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
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

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 8900 Bronze

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$8,900	\$17,800
		Family	\$17,800	\$35,600
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$9,200	\$30,300
		Family	\$18,400	\$60,600
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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%	50%
	Virtual Primary Care Visit		*\$0 per visit	Not Covered
	Specialty Care Physician Office Visits		10%	50%
	Chiropractic Services		10%	In Network Benefit Applies
	Acupuncture		10%	In Network Benefit Applies
	Urgent Care Visits		10%	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
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%
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		10%	50%
	X-Ray		10%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	10%	50%
Inpatient Services	10%	50%
Virtual Mental Health Visits	*\$0 per visit	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	*\$0	50%
Tier 2 - Non-Preferred Generic	*\$25	50%
Tier 3 - Preferred Brand	*\$65	50%
Tier 4 - Non-Preferred Brand	*\$100	50%
Tier 5 - Preferred Specialty	*\$300	50%
Tier 6 - Non-Preferred Specialty	*\$500	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	10%	50%
Maternity Inpatient	10%	50%
Newborn Care	10%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
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 HSA 2000 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Aggregate	Medical	Individual	\$2,000	\$4,000
		Family	\$4,000	\$8,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials	
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$4,000	\$16,500
		Family	\$8,000	\$33,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	\$0	50%
Tier 2 - Non-Preferred Generic	\$10	50%
Tier 3 - Preferred Brand	30%	50%
Tier 4 - Non-Preferred Brand	40%	50%
Tier 5 - Preferred Specialty	50%	50%
Tier 6 - Non-Preferred Specialty	50%	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	0%	50%
Maternity Inpatient	0%	50%
Newborn Care	0%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
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

Aggregate deductible definition - If one person is on the plan, he or she contributes to a single deductible. If more than one person is on the plan, they contribute to 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 HSA 3300 Gold

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$3,300	\$6,600
		Family	\$6,600	\$13,200
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$3,900	\$19,100
		Family	\$7,800	\$38,200
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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	10%	Not Covered	
	Primary Care Physician Office Visits	10%	50%	
	Virtual Primary Care Visit	10%	Not Covered	
	Specialty Care Physician Office Visits	10%	50%	
	Chiropractic Services	10%	In Network Benefit Applies	
	Acupuncture	10%	In Network Benefit Applies	
	Urgent Care Visits	10%	In Network Benefit Applies	
	Virtual Urgent Care Visits	10%	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	
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%	
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	10%	50%	
	X-Ray	10%	50%	

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	10%	50%
Inpatient Services	10%	50%
Virtual Mental Health Visits	10%	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	\$0	50%
Tier 2 - Non-Preferred Generic	\$10	50%
Tier 3 - Preferred Brand	30%	50%
Tier 4 - Non-Preferred Brand	40%	50%
Tier 5 - Preferred Specialty	50%	50%
Tier 6 - Non-Preferred Specialty	50%	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	10%	50%
Maternity Inpatient	10%	50%
Newborn Care	10%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
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 HSA 3500 Silver

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$3,500	\$7,000
		Family	\$7,000	\$14,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$7,500	\$19,500
		Family	\$15,000	\$39,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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	15%	Not Covered	
	Primary Care Physician Office Visits	15%	50%	
	Virtual Primary Care Visit	15%	Not Covered	
	Specialty Care Physician Office Visits	15%	50%	
	Chiropractic Services	15%	In Network Benefit Applies	
	Acupuncture	15%	In Network Benefit Applies	
	Urgent Care Visits	15%	In Network Benefit Applies	
	Virtual Urgent Care Visits	15%	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	
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%	
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	15%	50%	
	X-Ray	15%	50%	

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	15%	50%
Inpatient Services	15%	50%
Virtual Mental Health Visits	15%	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	\$0	50%
Tier 2 - Non-Preferred Generic	\$10	50%
Tier 3 - Preferred Brand	30%	50%
Tier 4 - Non-Preferred Brand	40%	50%
Tier 5 - Preferred Specialty	50%	50%
Tier 6 - Non-Preferred Specialty	50%	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	15%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
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.

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2025 POS HSA 5000 Silver

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$5,000	\$10,000
		Family	\$10,000	\$20,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials	
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$6,900	\$22,500
		Family	\$13,800	\$45,000
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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%	Not Covered	
	Primary Care Physician Office Visits	20%	50%	
	Virtual Primary Care Visit	20%	Not Covered	
	Specialty Care Physician Office Visits	20%	50%	
	Chiropractic Services	20%	In Network Benefit Applies	
	Acupuncture	20%	In Network Benefit Applies	
	Urgent Care Visits	20%	In Network Benefit Applies	
	Virtual Urgent Care Visits	20%	Not Covered	
	Allergy Treatment and Testing	20%	50%	
Emergency Services				
	Emergency Department Visits	20%	In Network Benefit Applies	
	Emergency Ambulance Transportation	20%	In Network Benefit Applies	
Hospital Services				
	Outpatient Surgery/Procedures Facility Fee	20%	50%	
	Outpatient Surgery/Procedures Physician/Surgeon Services	20%	50%	
	Inpatient Hospitalization Facility Fees	20%	50%	
	Inpatient Physician/Surgeon Fees	20%	50%	
Rehabilitative and Habilitative Services				
	Outpatient Rehabilitation Services (PT, OT, ST)	20%	50%	
	Inpatient Rehabilitation/Skilled Nursing Facility	20%	50%	
	Home Health	20%	50%	
Diagnostic Services				
	MRI and CT Scans	20%	50%	
	Laboratory	20%	50%	
	X-Ray	20%	50%	

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	20%	50%
Inpatient Services	20%	50%
Virtual Mental Health Visits	20%	Not Covered
Prescription Drugs		
<i>30 day supply</i>		
Tier 1 - Preferred Generic	\$0	50%
Tier 2 - Non-Preferred Generic	20%	50%
Tier 3 - Preferred Brand	20%	50%
Tier 4 - Non-Preferred Brand	20%	50%
Tier 5 - Preferred Specialty	50%	50%
Tier 6 - Non-Preferred Specialty	50%	50%
<i>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</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	20%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
Pediatric Vision Materials	*\$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	50%
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	20%	50%
Abortion Procedure Facility Fee	20%	50%
Abortion Procedure Physician Fee	20%	50%
Durable Medical Equipment	20%	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 HSA 7150 Bronze

Member Benefits	Member Responsibility			
		Participating (In-Network)	Non-Participating (Out-of-Network (OON))	
Plan Year Deductible Embedded	Medical	Individual	\$7,150	\$14,300
		Family	\$14,300	\$28,600
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
<i>Combined medical and pharmacy expenses including deductible, coinsurance & copayments.</i>	Medical/Pharmacy	Individual	\$7,150	\$26,800
		Family	\$14,300	\$53,600
<i>Dental OOPM goes toward medical OOPM</i>	Pediatric Dental	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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		
<i>30 day supply</i>		
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%
<p><i>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</i></p>		
Maternity		
<p><i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i></p>		
Routine Prenatal Care	0%	50%
Maternity Inpatient	0%	50%
Newborn Care	0%	50%
Pediatric Services		
<i>(members up to the age of 19 years old)</i>		
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Pediatric Vision Exam	*\$0 per exam	50%
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Preventive and Wellness Services		
<p><i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i></p>		
Wellness Care	*\$0	50%
Other Services		
<p><i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i></p>		
Other Covered Services	0%	50%
Abortion Procedure Facility Fee	0%	50%
Abortion Procedure Physician Fee	0%	50%
Durable Medical Equipment	0%	50%

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