Illinois

2025 Individual Direct Plans

Made for you.

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

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2025 POS 1000 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,000	$2,000
Embedded		Family	$2,000	$4,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,500	$14,500
		Family	$13,000	$29,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Matierals
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			30%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			*$1,500 per procedure	50%
Inpatient Hospitalization Facility Fees			^$1,500 per stay and Deductible then 30%	50%
Inpatient Physician/Surgeon Fees			30%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$20 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$50 per visit	50%
Chiropractic Services			*$50 per visit	In Network Benefit Applies
Acupuncture			*$20 per visit	In Network Benefit Applies
Urgent Care Visits			*$50 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			30%	50%
Emergency Services				
Emergency Department Visits			*$1,500 per visit	In Network Benefit Applies
Emergency Ambulance Transportation			30%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			30%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			30%	50%
Home Health			30%	50%
Diagnostic Services				
MRI and CT Scans			30%	50%
Laboratory			*$500 per test	50%
X-Ray			*$500 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$20 per visit	50%
Inpatient Services	^$1,500 per stay and Deductible then 30%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	30%	50%
Maternity Inpatient	^$1,500 per stay and Deductible then 30%	50%
Newborn Care	^$1,500 per stay and Deductible then 30%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	30%	50%
Abortion Procedure Facility Fee	30%	50%
Abortion Procedure Physician Fee	*$1,500 per procedure	50%
Durable Medical Equipment	30%	50%

* Deductible does not apply

^ Copay applies before the Deductible

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 POS 1500 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,500	$3,000
Embedded		Family	$3,000	$6,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,800	$15,500
		Family	$15,600	$31,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			25%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			25%	50%
Inpatient Hospitalization Facility Fees			25%	50%
Inpatient Physician/Surgeon Fees			25%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$30 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$60 per visit	50%
Chiropractic Services			*$60 per visit	In Network Benefit Applies
Acupuncture			*$30 per visit	In Network Benefit Applies
Urgent Care Visits			*$45 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			25%	50%
Emergency Services				
Emergency Department Visits			25%	In Network Benefit Applies
Emergency Ambulance Transportation			25%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			*$30 per visit	50%
Inpatient Rehabilitation/Skilled Nursing Facility			25%	50%
Home Health			25%	50%
Diagnostic Services				
MRI and CT Scans			25%	50%
Laboratory			25%	50%
X-Ray			25%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	50%
Inpatient Services	25%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$15	50%
Tier 2 - Non-Preferred Generic	*$15	50%
Tier 3 - Preferred Brand	*$30	50%
Tier 4 - Non-Preferred Brand	*$60	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$250	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	25%	50%
Maternity Inpatient	25%	50%
Newborn Care	25%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	50%
Abortion Procedure Facility Fee	25%	50%
Abortion Procedure Physician Fee	25%	50%
Durable Medical Equipment	25%	50%

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 HMO 1500 Elite Gold

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

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$30 per visit	Not Covered
Inpatient Services	25%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$15	Not Covered
Tier 2 - Non-Preferred Generic	*$15	Not Covered
Tier 3 - Preferred Brand	*$30	Not Covered
Tier 4 - Non-Preferred Brand	*$60	Not Covered
Tier 5 - Preferred Specialty	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	*$250	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	25%	Not Covered
Maternity Inpatient	25%	Not Covered
Newborn Care	25%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	Not Covered
Abortion Procedure Facility Fee	25%	Not Covered
Abortion Procedure Physician Fee	25%	Not Covered
Durable Medical Equipment	25%	Not Covered

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

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2025 POS 2500 Elite Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,500	$5,000
Embedded		Family	$5,000	$10,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,900	$17,500
		Family	$13,800	$35,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			15%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			15%	50%
Inpatient Hospitalization Facility Fees			15%	50%
Inpatient Physician/Surgeon Fees			15%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$25 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$50 per visit	50%
Chiropractic Services			*$50 per visit	In Network Benefit Applies
Acupuncture			*$25 per visit	In Network Benefit Applies
Urgent Care Visits			*$50 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			15%	50%
Emergency Services				
Emergency Department Visits			15%	In Network Benefit Applies
Emergency Ambulance Transportation			15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			15%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			15%	50%
Home Health			15%	50%
Diagnostic Services				
MRI and CT Scans			15%	50%
Laboratory			*$100 per test	50%
X-Ray			*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$25 per visit	50%
Inpatient Services	15%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	15%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	15%	50%
Abortion Procedure Facility Fee	15%	50%
Abortion Procedure Physician Fee	15%	50%
Durable Medical Equipment	15%	50%

* Deductible does not apply

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When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 POS 4200 Silver Select

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$4,200	$8,400
Embedded		Family	$8,400	$16,800
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$20,900
		Family	$18,400	$41,800
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			40%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			40%	50%
Inpatient Hospitalization Facility Fees			40%	50%
Inpatient Physician/Surgeon Fees			40%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$40 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$80 per visit	50%
Chiropractic Services			*$80 per visit	In Network Benefit Applies
Acupuncture			*$40 per visit	In Network Benefit Applies
Urgent Care Visits			*$55 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			40%	50%
Emergency Services				
Emergency Department Visits			40%	In Network Benefit Applies
Emergency Ambulance Transportation			40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			*$50 per visit	50%
Inpatient Rehabilitation/Skilled Nursing Facility			40%	50%
Home Health			40%	50%
Diagnostic Services				
MRI and CT Scans			40%	50%
Laboratory			*$150 per test	50%
X-Ray			*$300 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$10	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	*$80	50%
Tier 5 - Preferred Specialty	*$250	50%
Tier 6 - Non-Preferred Specialty	*$400	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	50%

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 POS 5000 Silver Select

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$5,000	$10,000
Embedded		Family	$10,000	$20,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,000	$22,500
		Family	$16,000	$45,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			40%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			40%	50%
Inpatient Hospitalization Facility Fees			40%	50%
Inpatient Physician/Surgeon Fees			40%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$40 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$80 per visit	50%
Chiropractic Services			*$80 per visit	In Network Benefit Applies
Acupuncture			*$40 per visit	In Network Benefit Applies
Urgent Care Visits			*$60 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			40%	50%
Emergency Services				
Emergency Department Visits			40%	In Network Benefit Applies
Emergency Ambulance Transportation			40%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			*$40 per visit	50%
Inpatient Rehabilitation/Skilled Nursing Facility			40%	50%
Home Health			40%	50%
Diagnostic Services				
MRI and CT Scans			40%	50%
Laboratory			40%	50%
X-Ray			40%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	40%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$20	50%
Tier 3 - Preferred Brand	*$40	50%
Tier 4 - Non-Preferred Brand	$80	50%
Tier 5 - Preferred Specialty	$350	50%
Tier 6 - Non-Preferred Specialty	$350	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	40%	50%
Maternity Inpatient	40%	50%
Newborn Care	40%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	50%
Abortion Procedure Facility Fee	40%	50%
Abortion Procedure Physician Fee	40%	50%
Durable Medical Equipment	40%	50%

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 HMO 5000 Elite Silver

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

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	Not Covered
Inpatient Services	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$20	Not Covered
Tier 2 - Non-Preferred Generic	*$20	Not Covered
Tier 3 - Preferred Brand	*$40	Not Covered
Tier 4 - Non-Preferred Brand	$80	Not Covered
Tier 5 - Preferred Specialty	$350	Not Covered
Tier 6 - Non-Preferred Specialty	$350	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	40%	Not Covered
Maternity Inpatient	40%	Not Covered
Newborn Care	40%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	Not Covered
Preventive Dental Services	*$0 per visit	Not Covered
Minor Dental Restorative	50%	Not Covered
Major Dental Services	50%	Not Covered
Medically Necessary Orthodontia Services	*50%	Not Covered
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	In Network Benefit Applies
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	40%	Not Covered
Abortion Procedure Facility Fee	40%	Not Covered
Abortion Procedure Physician Fee	40%	Not Covered
Durable Medical Equipment	40%	Not Covered

* Deductible does not apply

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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Health Alliance™

2025 POS 7250 Silver Select

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,250	$14,500
Embedded		Family	$14,500	$29,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$27,000
		Family	$18,400	$54,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			15%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			15%	50%
Inpatient Hospitalization Facility Fees			15%	50%
Inpatient Physician/Surgeon Fees			15%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$40 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$80 per visit	50%
Chiropractic Services			*$80 per visit	In Network Benefit Applies
Acupuncture			*$40 per visit	In Network Benefit Applies
Urgent Care Visits			*$60 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			15%	50%
Emergency Services				
Emergency Department Visits			15%	In Network Benefit Applies
Emergency Ambulance Transportation			15%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			15%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			15%	50%
Home Health			15%	50%
Diagnostic Services				
MRI and CT Scans			15%	50%
Laboratory			*$100 per test	50%
X-Ray			*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$40 per visit	50%
Inpatient Services	15%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$30	50%
Tier 3 - Preferred Brand	*$60	50%
Tier 4 - Non-Preferred Brand	*$100	50%
Tier 5 - Preferred Specialty	*$300	50%
Tier 6 - Non-Preferred Specialty	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	15%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	15%	50%
Abortion Procedure Facility Fee	15%	50%
Abortion Procedure Physician Fee	15%	50%
Durable Medical Equipment	15%	50%

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 POS 6500 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$6,500	$13,000
Embedded		Family	$13,000	$26,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$25,500
		Family	$18,400	$51,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			25%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			25%	50%
Inpatient Hospitalization Facility Fees			25%	50%
Inpatient Physician/Surgeon Fees			25%	50%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			25%	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			25%	50%
Chiropractic Services			25%	In Network Benefit Applies
Acupuncture			25%	In Network Benefit Applies
Urgent Care Visits			*$80 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			25%	50%
Emergency Services				
Emergency Department Visits			25%	In Network Benefit Applies
Emergency Ambulance Transportation			25%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			25%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			25%	50%
Home Health			25%	50%
Diagnostic Services				
MRI and CT Scans			25%	50%
Laboratory			*$150 per test	50%
X-Ray			*$200 per test	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	25%	50%
Inpatient Services	25%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$30	50%
Tier 3 - Preferred Brand	*$60	50%
Tier 4 - Non-Preferred Brand	*$100	50%
Tier 5 - Preferred Specialty	*$300	50%
Tier 6 - Non-Preferred Specialty	*$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	25%	50%
Maternity Inpatient	25%	50%
Newborn Care	25%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	25%	50%
Abortion Procedure Facility Fee	25%	50%
Abortion Procedure Physician Fee	25%	50%
Durable Medical Equipment	25%	50%

* Deductible does not apply

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Health Alliance™

2025 POS HSA 7350 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,350	$14,700
Embedded		Family	$14,700	$29,400
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,350	$27,200
		Family	$14,700	$54,400
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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%
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
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 Behavioral Health Visits	0%	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	0%	50%
Tier 2 - Non-Preferred Generic	0%	50%
Tier 3 - Preferred Brand	0%	50%
Tier 4 - Non-Preferred Brand	0%	50%
Tier 5 - Preferred Specialty	0%	50%
Tier 6 - Non-Preferred Specialty	0%	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	0%	50%
Maternity Inpatient	0%	50%
Newborn Care	0%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	50%
Abortion Procedure Facility Fee	0%	50%
Abortion Procedure Physician Fee	0%	50%
Durable Medical Equipment	0%	50%

* Deductible does not apply

Embedded deductible definition - If two or more members have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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Health Alliance™

2025 POS 7500 Elite Bronze

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,500	$15,000
Embedded		Family	$15,000	$30,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	Refer to Delta Dental Materials	Refer to Delta Dental Materials
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$9,200	$27,500
		Family	$18,400	$55,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	Refer to Delta Dental Materials	Refer to Delta Dental Materials
		Family	Refer to Delta Dental Materials	Refer to Delta Dental Materials
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%
Contract Year Maximum Benefits				
Cardiac Rehabilitation Services			36 OP sessions w/in 6 month of event combined in-net and OON	
Outpatient Rehabilitation Services			60 visits per condition per plan year combined in-net and OON	
Habilitative Services			60 visits per condition per plan year combined in-net and OON	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Chiropractic Services			25 visits per plan year combined in-net and OON	
Adult Vision Exam			Once every 12 months.	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Pediatric Dental Exam			Once every 6 months combined in-net and OON	
Pediatric Vision Therapy			12 visits for treatment of Convergence Insufficiency per plan year	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Primary Care Physician Office Visits			*$50 per visit	50%
Virtual Primary Care Visit			*$0 per visit	Not Covered
Specialty Care Physician Office Visits			*$100 per visit	50%
Chiropractic Services			*$100 per visit	In Network Benefit Applies
Acupuncture			*$50 per visit	In Network Benefit Applies
Urgent Care Visits			*$75 per visit	In Network Benefit Applies
Virtual Urgent Care Visits			*$0 per visit	Not Covered
Allergy Treatment and Testing			50%	50%
Emergency Services				
Emergency Department Visits			50%	In Network Benefit Applies
Emergency Ambulance Transportation			50%	In Network Benefit Applies
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			*$50 per visit	50%
Inpatient Rehabilitation/Skilled Nursing Facility			50%	50%
Home Health			50%	50%
Diagnostic Services				
MRI and CT Scans			50%	50%
Laboratory			50%	50%
X-Ray			50%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Mental Health/Substance Use Treatment		
Outpatient Office Visits	*$50 per visit	50%
Inpatient Services	50%	50%
Virtual Behavioral Health Visits	*$0 per visit	Not Covered
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$25	50%
Tier 2 - Non-Preferred Generic	*$25	50%
Tier 3 - Preferred Brand	$50	50%
Tier 4 - Non-Preferred Brand	$100	50%
Tier 5 - Preferred Specialty	$500	50%
Tier 6 - Non-Preferred Specialty	$500	50%
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug		
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	50%	50%
Maternity Inpatient	50%	50%
Newborn Care	50%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	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		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	50%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	50%	50%
Abortion Procedure Facility Fee	50%	50%
Abortion Procedure Physician Fee	50%	50%
Durable Medical Equipment	50%	50%

* Deductible does not apply

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When using out of network providers, you also pay any charges in excess of the **maximum allowable charge**. Amounts over the maximum allowable charge do not apply to the Out-of-Pocket Maximum.

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2025 Simplete Memorial HMO Limited Network 2500 Gold

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

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$5 per visit	*$40 per visit	Not Covered
Inpatient Services	20%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$10	*$10	Not Covered
Tier 3 - Preferred Brand	*$40	*$40	Not Covered
Tier 4 - Non-Preferred Brand	*$80	*$80	Not Covered
Tier 5 - Preferred Specialty	*$250	*$250	Not Covered
Tier 6 - Non-Preferred Specialty	*$400	*$400	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
Maternity			
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.			
Routine Prenatal Care	20%	40%	Not Covered
Maternity Inpatient	20%	40%	Not Covered
Newborn Care	20%	40%	Not Covered
Pediatric Services			
(members up to the age of 19 years old)			
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services			
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.			
Wellness Care	*$0	*$0	Not Covered
Other Services			
Other services covered within your policy and not otherwise specified on this summary or on the SBC.			
Other Covered Services	20%	40%	Not Covered
Abortion Procedure Facility Fee	20%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 20%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	20%	40%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance™

2025 Simplete Memorial HMO Limited Network 3500 Silver Select

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

Member Benefits	Participating (In-Network Tier 1)	Participating (In-Network Tier 2)	Non-Participating (Out-of-Network (OON) Tier 3)
Mental Health/Substance Use Treatment			
Outpatient Office Visits	*$10 per visit	40%	Not Covered
Inpatient Services	30%	40%	Not Covered
Virtual Mental Health Visits	*$0 per visit	*$0 per visit	Not Covered
Prescription Drugs			
30 day supply			
Tier 1 - Preferred Generic	*$0	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$30	*$30	Not Covered
Tier 3 - Preferred Brand	*$60	*$60	Not Covered
Tier 4 - Non-Preferred Brand	*$100	*$100	Not Covered
Tier 5 - Preferred Specialty	*$300	*$300	Not Covered
Tier 6 - Non-Preferred Specialty	*$500	*$500	Not Covered
If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug			
Maternity			
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.			
Routine Prenatal Care	30%	40%	Not Covered
Maternity Inpatient	30%	40%	Not Covered
Newborn Care	30%	40%	Not Covered
Pediatric Services			
(members up to the age of 19 years old)			
Pediatric Dental Exam	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Preventive Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Minor Dental Restorative	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Major Dental Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Medically Necessary Orthodontia Services	Refer to Delta Dental Materials	Refer to Delta Dental Materials	Not Covered
Pediatric Vision Exam	*$0 per exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	*$0 per item	Tier 2 Benefit Applies
Preventive and Wellness Services			
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.			
Wellness Care	*$0	*$0	Not Covered
Other Services			
Other services covered within your policy and not otherwise specified on this summary or on the SBC.			
Other Covered Services	30%	40%	Not Covered
Abortion Procedure Facility Fee	30%	40%	Not Covered
Abortion Procedure Physician Fee	^$150 per procedure and Deductible then 30%	^$150 per procedure and Deductible then 40%	Not Covered
Durable Medical Equipment	30%	40%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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