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.

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.