Health Alliance™

2025 POS 7250 Elite Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$7,250	$14,500
Embedded		Family	$14,500	$29,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	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 Mental 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 screenings & 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.

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.