Iowa

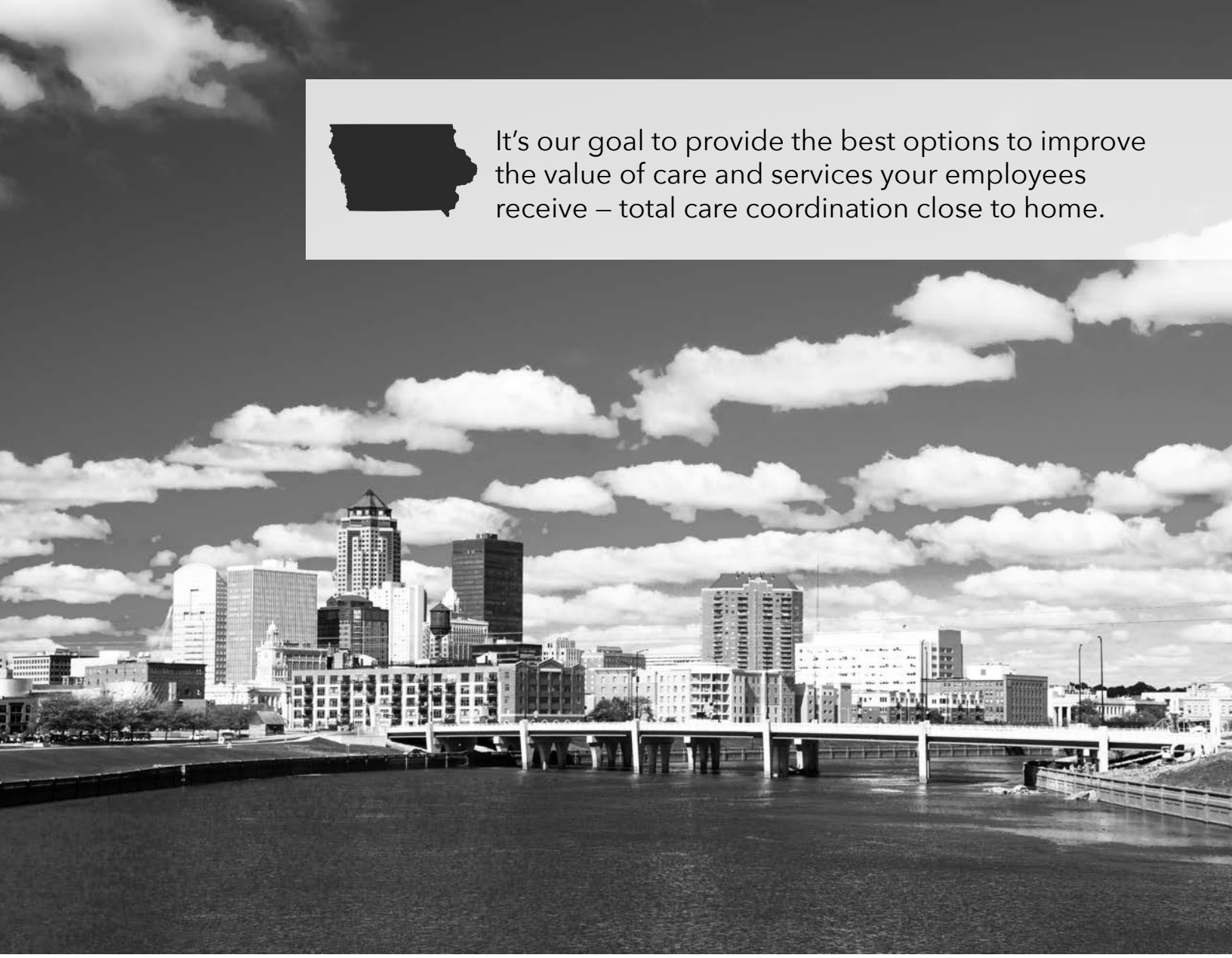
2021 Small Group Plans

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 Iowa is defined as 1–50 total eligible employees.

Health Alliance™



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.

Personalized, World-Class Coverage

Health Alliance is the largest health insurer based in downstate Illinois, with member-focused health plans in four states – Illinois, Iowa, Indiana and Ohio. Our sister company, Health Alliance Northwest, began offering coverage in Washington in 2014. Our nearly 700 employees serve more than 230,000 members across all five 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.

Helpful and Accessible Service

We aren't just another insurance option. We give personal attention to you and your employees. We provide you with your own Health Alliance business consultant to answer questions about your plan, and your employees can always get quick answers through our Customer Service.

Life is unpredictable, and sickness or injury is bound to happen. That's why your employees deserve coverage made for whatever life has in store 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.
- Online and mobile self-service at Hally.com and with the Hally™ app. Wellness programs that help your members take charge of their health.
- Travel support through Assist America™.
- Pharmacy discount programs.

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

Structure

- Only care received within the HMO network is covered.
- Out-of-network coverage is available in emergencies or when preauthorization 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 Health Care Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

Considerations

- A PCP gives attention to members' personalized, overall health and serves as their healthcare partner.
- Health Alliance has a strong network of top-notch doctors, hospitals, clinics and pharmacies throughout Iowa and Illinois.

Health Alliance

2021 HMO 500 Platinum

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$500	Not Applicable
Embedded		Family	$1,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$3,500	Not Applicable
		Family	$7,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
		Adult Vision Exam	Once every 12 months.	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months.	
		Pediatric Vision Materials	Once every 12 months.	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Virtual Visits	*$0 visits 1-3, then $20 copay	Not Covered
		Primary Care Physician Office Visits	*$20 per visit	Not Covered
		Specialty Care Physician Office Visits	*$45 per visit	Not Covered
		Chiropractic Services	*$45 per visit	Not Covered
		Acupuncture	*$20 per visit	Not Covered
		Urgent Care Visits	*$45 per visit	In Network Benefit Applies
		Allergy Treatment and Testing	20%	Not Covered
Emergency Services				
		Emergency Department Visits	*$300 then 20% per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	20%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	20%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	20%	Not Covered
		Inpatient Hospitalization Facility Fees	20%	Not Covered
		Inpatient Physician/Surgeon Fees	20%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	20%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	20%	Not Covered
		Home Health	20%	Not Covered
Diagnostic Services				
		MRI and CT Scans	20%	Not Covered
		Laboratory and X-rays	20%	Not Covered
Mental Health/Substance Use Treatment				
		Outpatient Office Visits	*$20 per visit	Not Covered
		Inpatient Services	20%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	Not Covered
Tier 2 - Non-Preferred Generic	*$10	Not Covered
Tier 3 - Preferred Brand	*$35	Not Covered
Tier 4 - Non-Preferred Brand	*$70	Not Covered
Tier 5 - Preferred Specialty	*50%	Not Covered
Tier 6 - Non-Preferred Specialty	*50%	Not Covered
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%	Not Covered
Maternity Inpatient	20%	Not Covered
Newborn Care	20%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	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%	Not Covered
Durable Medical Equipment	20%	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

2021 HMO 1000 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$1,000	Not Applicable
Embedded		Family	$2,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,000	Not Applicable
		Family	$12,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year	
Pediatric Vision Exam			Once every 12 months.	
Pediatric Vision Materials			Once every 12 months.	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 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
Allergy Treatment and Testing			20%	Not Covered
Emergency Services				
Emergency Department Visits			*$400 then 20% per visit	In Network Benefit Applies
Emergency Ambulance Transportation			20%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 20%	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			^$150 per procedure and Deductible then 20%	Not Covered
Inpatient Hospitalization Facility Fees			20%	Not Covered
Inpatient Physician/Surgeon Fees			20%	Not Covered
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			20%	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			20%	Not Covered
Home Health			20%	Not Covered
Diagnostic Services				
MRI and CT Scans			20%	Not Covered
Laboratory and X-rays			20%	Not Covered
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	Not Covered
Inpatient Services			20%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	Not Covered
Tier 6 - Non-Preferred Specialty	*50%	Not Covered
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%	Not Covered
Maternity Inpatient	20%	Not Covered
Newborn Care	20%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	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%	Not Covered
Durable Medical Equipment	20%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 HMO 2000 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,000	Not Applicable
Embedded		Family	$4,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,000	Not Applicable
		Family	$12,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
		Adult Vision Exam	Once every 12 months.	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months.	
		Pediatric Vision Materials	Once every 12 months.	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Virtual Visits	*$0 visits 1-3, then $25 copay	Not Covered
		Primary Care Physician Office Visits	*$25 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
		Allergy Treatment and Testing	10%	Not Covered
Emergency Services				
		Emergency Department Visits	*$400 then 10% per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	10%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	^$150 per procedure and Deductible then 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 and X-rays	10%	Not Covered
Mental Health/Substance Use Treatment				
		Outpatient Office Visits	*$25 per visit	Not Covered
		Inpatient Services	10%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	Not Covered
Tier 6 - Non-Preferred Specialty	*50%	Not Covered
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	10%	Not Covered
Maternity Inpatient	10%	Not Covered
Newborn Care	10%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	Not Covered
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	10%	Not Covered
Durable Medical Equipment	10%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 HMO 2500 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,500	Not Applicable
Embedded		Family	$5,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
		Dental Per Member	$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$5,000	Not Applicable
		Family	$10,000	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
		Adult Vision Exam	Once every 12 months.	
		Acupuncture Treatment	15 visits per plan year	
		Pediatric Vision Exam	Once every 12 months.	
		Pediatric Vision Materials	Once every 12 months.	
Ambulatory Patient Services				
		Vision Exam	*$20 per exam	Not Covered
		Virtual Visits	*$0 visits 1-3, then $25 copay	Not Covered
		Primary Care Physician Office Visits	*$25 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
		Allergy Treatment and Testing	20%	Not Covered
Emergency Services				
		Emergency Department Visits	*$400 then 20% per visit	In Network Benefit Applies
		Emergency Ambulance Transportation	20%	In Network Benefit Applies
Hospital Services				
		Outpatient Surgery/Procedures Facility Fee	^$150 per procedure and Deductible then 20%	Not Covered
		Outpatient Surgery/Procedures Physician/Surgeon Services	^$150 per procedure and Deductible then 20%	Not Covered
		Inpatient Hospitalization Facility Fees	20%	Not Covered
		Inpatient Physician/Surgeon Fees	20%	Not Covered
Rehabilitative and Habilitative Services				
		Outpatient Rehabilitation Services (PT, OT, ST)	20%	Not Covered
		Inpatient Rehabilitation/Skilled Nursing Facility	20%	Not Covered
		Home Health	20%	Not Covered
Diagnostic Services				
		MRI and CT Scans	20%	Not Covered
		Laboratory and X-rays	20%	Not Covered
Mental Health/Substance Use Treatment				
		Outpatient Office Visits	*$25 per visit	Not Covered
		Inpatient Services	20%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	Not Covered
Tier 6 - Non-Preferred Specialty	*50%	Not Covered
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%	Not Covered
Maternity Inpatient	20%	Not Covered
Newborn Care	20%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	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%	Not Covered
Durable Medical Equipment	20%	Not Covered

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 HMO 6500 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$6,500	Not Applicable
Embedded		Family	$13,000	Not Applicable
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,150	Not Applicable
		Family	$16,300	Not Applicable
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year	
Pediatric Vision Exam			Once every 12 months.	
Pediatric Vision Materials			Once every 12 months.	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $35 copay	Not Covered
Primary Care Physician Office Visits			*$35 per visit	Not Covered
Specialty Care Physician Office Visits			*$70 per visit	Not Covered
Chiropractic Services			*$70 per visit	Not Covered
Acupuncture			*$35 per visit	Not Covered
Urgent Care Visits			*$70 per visit	In Network Benefit Applies
Allergy Treatment and Testing			20%	Not Covered
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			^$200 per procedure and Deductible then 20%	Not Covered
Outpatient Surgery/Procedures Physician/Surgeon Services			^$200 per procedure and Deductible then 20%	Not Covered
Inpatient Hospitalization Facility Fees			20%	Not Covered
Inpatient Physician/Surgeon Fees			20%	Not Covered
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			20%	Not Covered
Inpatient Rehabilitation/Skilled Nursing Facility			20%	Not Covered
Home Health			20%	Not Covered
Diagnostic Services				
MRI and CT Scans			20%	Not Covered
Laboratory and X-rays			20%	Not Covered
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$35 per visit	Not Covered
Inpatient Services			20%	Not Covered

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	Not Covered
Tier 6 - Non-Preferred Specialty	*50%	Not Covered
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%	Not Covered
Maternity Inpatient	20%	Not Covered
Newborn Care	20%	Not Covered
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
Pediatric Vision Exam	*$0 per exam	Not Covered
Pediatric Vision Materials	*$0 per item	Not Covered
Preventive and Wellness Services		
Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.		
Wellness Care	*$0	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%	Not Covered
Durable Medical Equipment	20%	Not Covered

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POS

Structure

- Coverage is determined at the point-of-service, 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 preauthorization is given.
- Members select a primary care provider (PCP) to coordinate all medical care.
- For in-network specialty care, a PCP gives a referral to an in-network specialist. Specialty care sought without a referral or out-of-network is covered at the lower benefit level.
- Women can select a Woman's Principal Health Care Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

Considerations

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

Health Alliance

2021 POS 1500 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		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,000	$15,500
		Family	$12,000	$31,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 per visit	50%
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
Allergy Treatment and Testing			20%	50%
Emergency Services				
Emergency Department Visits			*$400 then 20% per visit	In Network Benefit Applies
Emergency Ambulance Transportation			20%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	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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Health Alliance

2021 POS 2000 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,000	$4,000
Embedded		Family	$4,000	$8,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$5,000	$16,500
		Family	$10,000	$33,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 per visit	50%
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
Allergy Treatment and Testing			20%	50%
Emergency Services				
Emergency Department Visits			*$400 then 20% per visit	In Network Benefit Applies
Emergency Ambulance Transportation			20%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	20%	50%
Durable Medical Equipment	20%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 POS 2500 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		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$5,500	$17,500
		Family	$11,000	$35,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 per visit	50%
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
Allergy Treatment and Testing			20%	50%
Emergency Services				
Emergency Department Visits			^$400 per visit and Deductible then 20%	In Network Benefit Applies
Emergency Ambulance Transportation			20%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	20%	50%
Durable Medical Equipment	20%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 POS 3000 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,000	$6,000
Embedded		Family	$6,000	$12,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,000	$16,000
		Family	$12,000	$32,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 per visit	40%
Specialty Care Physician Office Visits			*$60 per visit	40%
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
Allergy Treatment and Testing			10%	40%
Emergency Services				
Emergency Department Visits			*$400 then 10% per visit	In Network Benefit Applies
Emergency Ambulance Transportation			10%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 10%	40%
Outpatient Surgery/Procedures Physician/Surgeon Services			^$150 per procedure and Deductible then 10%	40%
Inpatient Hospitalization Facility Fees			10%	40%
Inpatient Physician/Surgeon Fees			10%	40%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			10%	40%
Inpatient Rehabilitation/Skilled Nursing Facility			10%	40%
Home Health			10%	40%
Diagnostic Services				
MRI and CT Scans			10%	40%
Laboratory and X-rays			10%	40%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	40%
Inpatient Services			10%	40%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	10%	40%
Maternity Inpatient	10%	40%
Newborn Care	10%	40%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	40%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	10%	40%
Durable Medical Equipment	10%	40%

* Deductible does not apply

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Health Alliance

2021 POS 3500 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,500	$7,000
Embedded		Family	$7,000	$14,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,000	$19,500
		Family	$14,000	$39,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $25 copay	Not Covered
Primary Care Physician Office Visits			*$25 per visit	50%
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
Allergy Treatment and Testing			20%	50%
Emergency Services				
Emergency Department Visits			^$400 per visit and Deductible then 20%	In Network Benefit Applies
Emergency Ambulance Transportation			20%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$150 per procedure and Deductible then 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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$25 per visit	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	20%	50%
Durable Medical Equipment	20%	50%

* Deductible does not apply

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Health Alliance

2021 POS 3800 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,800	$7,600
Embedded		Family	$7,600	$15,200
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,150	$20,100
		Family	$16,300	$40,200
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $35 copay	Not Covered
Primary Care Physician Office Visits			*$35 per visit	50%
Specialty Care Physician Office Visits			*$70 per visit	50%
Chiropractic Services			*$70 per visit	In Network Benefit Applies
Acupuncture			*$35 per visit	In Network Benefit Applies
Urgent Care Visits			*$70 per visit	In Network Benefit Applies
Allergy Treatment and Testing			35%	50%
Emergency Services				
Emergency Department Visits			^$400 per visit and Deductible then 35%	In Network Benefit Applies
Emergency Ambulance Transportation			35%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$200 per procedure and Deductible then 35%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			^$200 per procedure and Deductible then 35%	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 and X-rays			35%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$35 per visit	50%
Inpatient Services			35%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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	35%	50%
Maternity Inpatient	35%	50%
Newborn Care	35%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	35%	50%
Durable Medical Equipment	35%	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

2021 POS 5500 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$5,500	$11,000
Embedded		Family	$11,000	$22,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$8,150	$23,500
		Family	$16,300	$47,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $35 copay	Not Covered
Primary Care Physician Office Visits			*$35 per visit	50%
Specialty Care Physician Office Visits			*$70 per visit	50%
Chiropractic Services			*$70 per visit	In Network Benefit Applies
Acupuncture			*$35 per visit	In Network Benefit Applies
Urgent Care Visits			*$70 per visit	In Network Benefit Applies
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			^$200 per procedure and Deductible then 20%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			^$200 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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$35 per visit	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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	*50%	50%
Tier 6 - Non-Preferred Specialty	*50%	50%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	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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Health Alliance

2021 POS HSA 2000 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,000	$4,000
Aggregate		Family	$4,000	$8,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$4,000	$11,500
		Family	$8,000	$23,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			0%	Not Covered
Virtual Visits			^$0 visits 1-3, and Deductible then 0%	Not Covered
Primary Care Physician Office Visits			0%	30%
Specialty Care Physician Office Visits			0%	30%
Chiropractic Services			0%	In Network Benefit Applies
Acupuncture			0%	In Network Benefit Applies
Urgent Care Visits			0%	In Network Benefit Applies
Allergy Treatment and Testing			0%	30%
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%	30%
Outpatient Surgery/Procedures Physician/Surgeon Services			0%	30%
Inpatient Hospitalization Facility Fees			0%	30%
Inpatient Physician/Surgeon Fees			0%	30%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			0%	30%
Inpatient Rehabilitation/Skilled Nursing Facility			0%	30%
Home Health			0%	30%
Diagnostic Services				
MRI and CT Scans			0%	30%
Laboratory and X-rays			0%	30%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			0%	30%
Inpatient Services			0%	30%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	0%	30%
Maternity Inpatient	0%	30%
Newborn Care	0%	30%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	30%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	30%
Durable Medical Equipment	0%	30%

* Deductible does not apply

^ Copay applies before the Deductible

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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Health Alliance

2021 POS HSA 2800 Gold

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,800	$5,600
Embedded		Family	$5,600	$11,200
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$4,500	$13,100
		Family	$9,000	$26,200
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			10%	Not Covered
Virtual Visits			^$0 visits 1-3, and Deductible then 10%	Not Covered
Primary Care Physician Office Visits			10%	30%
Specialty Care Physician Office Visits			10%	30%
Chiropractic Services			10%	In Network Benefit Applies
Acupuncture			10%	In Network Benefit Applies
Urgent Care Visits			10%	In Network Benefit Applies
Allergy Treatment and Testing			10%	30%
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%	30%
Outpatient Surgery/Procedures Physician/Surgeon Services			10%	30%
Inpatient Hospitalization Facility Fees			10%	30%
Inpatient Physician/Surgeon Fees			10%	30%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			10%	30%
Inpatient Rehabilitation/Skilled Nursing Facility			10%	30%
Home Health			10%	30%
Diagnostic Services				
MRI and CT Scans			10%	30%
Laboratory and X-rays			10%	30%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			10%	30%
Inpatient Services			10%	30%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	10%	30%
Maternity Inpatient	10%	30%
Newborn Care	10%	30%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	30%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	10%	30%
Durable Medical Equipment	10%	30%

* 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

2021 POS HSA 3500 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$3,500	$7,000
Embedded		Family	$7,000	$14,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,900	$19,500
		Family	$13,800	$39,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			15%	Not Covered
Virtual Visits			^$0 visits 1-3, and Deductible then 15%	Not Covered
Primary Care Physician Office Visits			15%	50%
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
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 and X-rays			15%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			15%	50%
Inpatient Services			15%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	15%	50%
Maternity Inpatient	15%	50%
Newborn Care	15%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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%
Durable Medical Equipment	15%	50%

* Deductible does not apply

^ Copay applies before the Deductible

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Health Alliance

2021 POS HSA 5000 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$5,000	$10,000
Embedded		Family	$10,000	$20,000
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$6,600	$22,500
		Family	$13,200	$45,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			20%	Not Covered
Virtual Visits			^$0 visits 1-3, and Deductible then 20%	Not Covered
Primary Care Physician Office Visits			20%	50%
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
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 and X-rays			20%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			20%	50%
Inpatient Services			20%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
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%
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%	50%
Maternity Inpatient	20%	50%
Newborn Care	20%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	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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Health Alliance

2021 POS HSA 6500 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		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,000	$20,500
		Family	$14,000	$41,000
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			0%	Not Covered
Virtual Visits			^$0 visits 1-3, and Deductible then 0%	Not Covered
Primary Care Physician Office Visits			0%	30%
Specialty Care Physician Office Visits			0%	30%
Chiropractic Services			0%	In Network Benefit Applies
Acupuncture			0%	In Network Benefit Applies
Urgent Care Visits			0%	In Network Benefit Applies
Allergy Treatment and Testing			0%	30%
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%	30%
Outpatient Surgery/Procedures Physician/Surgeon Services			0%	30%
Inpatient Hospitalization Facility Fees			0%	30%
Inpatient Physician/Surgeon Fees			0%	30%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			0%	30%
Inpatient Rehabilitation/Skilled Nursing Facility			0%	30%
Home Health			0%	30%
Diagnostic Services				
MRI and CT Scans			0%	30%
Laboratory and X-rays			0%	30%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			0%	30%
Inpatient Services			0%	30%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	$0	50%
Tier 2 - Non-Preferred Generic	0%	50%
Tier 3 - Preferred Brand	50%	50%
Tier 4 - Non-Preferred Brand	50%	50%
Tier 5 - Preferred Specialty	50%	50%
Tier 6 - Non-Preferred Specialty	50%	50%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	0%	30%
Maternity Inpatient	0%	30%
Newborn Care	0%	30%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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	30%
Other Services		
Other services covered within your policy and not otherwise specified on this summary or on the SBC.		
Other Covered Services	0%	30%
Durable Medical Equipment	0%	30%

* 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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POSC

- Coverage is determined at the point of service, depending on the provider chosen. When choosing an in-network provider, HMO-style benefits apply. When choosing an out-of-network provider, indemnity benefits apply (except in urgent or emergency situations).
- Members select a primary care provider (PCP) to coordinate all medical care.
- For in-network specialty care, a PCP gives a referral to an in-network specialist. Specialty care received without a referral or from an out-of-network provider is covered at the lower (indemnity) level.
- Women can select a Woman's Principal Health Care Provider (specializing in obstetrics, gynecology or family practice) in addition to a PCP.

Health Alliance

2021 POS-C 2800 Silver

Member Benefits			Member Responsibility Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible	**Medical**	Individual	$2,800	$5,600
Embedded		Family	$5,600	$11,200
	Pharmacy	Individual	Not Applicable	Not Applicable
		Family	Not Applicable	Not Applicable
	Dental Per Member		$75	$75
Plan Year Out-of-Pocket Maximum (OOPM)				
Combined medical and pharmacy expenses including deductible, coinsurance & copayments.	**Medical/Pharmacy**	Individual	$7,000	$18,100
		Family	$14,000	$36,200
Dental OOPM goes toward medical OOPM	**Pediatric Dental**	Individual	$350	Combined with In Network
		Family	$700	Combined with In Network
Contract Year Maximum Benefits				
Adult Vision Exam			Once every 12 months.	
Acupuncture Treatment			15 visits per plan year combined in-net and OON	
Pediatric Vision Exam			Once every 12 months combined in-net and OON	
Pediatric Vision Materials			Once every 12 months combined in-net and OON	
Ambulatory Patient Services				
Vision Exam			*$20 per exam	Not Covered
Virtual Visits			*$0 visits 1-3, then $35 copay	Not Covered
Primary Care Physician Office Visits			*$35 per visit	50%
Specialty Care Physician Office Visits			*$70 per visit	50%
Chiropractic Services			*$70 per visit	In Network Benefit Applies
Acupuncture			*$35 per visit	In Network Benefit Applies
Urgent Care Visits			*$70 per visit	In Network Benefit Applies
Allergy Treatment and Testing			30%	50%
Emergency Services				
Emergency Department Visits			^$400 per visit and Deductible then 30%	In Network Benefit Applies
Emergency Ambulance Transportation			30%	In Network Benefit Applies
Hospital Services				
Outpatient Surgery/Procedures Facility Fee			^$200 per procedure and Deductible then 30%	50%
Outpatient Surgery/Procedures Physician/Surgeon Services			^$200 per procedure and Deductible then 30%	50%
Inpatient Hospitalization Facility Fees			30%	50%
Inpatient Physician/Surgeon Fees			30%	50%
Rehabilitative and Habilitative Services				
Outpatient Rehabilitation Services (PT, OT, ST)			30%	50%
Inpatient Rehabilitation/Skilled Nursing Facility			30%	50%
Home Health			30%	50%
Diagnostic Services				
MRI and CT Scans			30%	50%
Laboratory and X-rays			30%	50%
Mental Health/Substance Use Treatment				
Outpatient Office Visits			*$35 per visit	50%
Inpatient Services			30%	50%

Member Benefits	Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Prescription Drugs		
30 day supply		
Tier 1 - Preferred Generic	*$0	50%
Tier 2 - Non-Preferred Generic	*$15	50%
Tier 3 - Preferred Brand	*$60	50%
Tier 4 - Non-Preferred Brand	30%	50%
Tier 5 - Preferred Specialty	30%	50%
Tier 6 - Non-Preferred Specialty	30%	50%
Maternity		
Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.		
Routine Prenatal Care	30%	50%
Maternity Inpatient	30%	50%
Newborn Care	30%	50%
Pediatric Services		
(members up to the age of 19 years old)		
Pediatric Dental Exam	*$0 per exam	*50%
Preventive Dental Services	*$0 per visit	*50%
Minor Dental Restorative	40%	50%
Major Dental Services	50%	50%
Medically Necessary Orthodontia Services	50%	50%
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%
Durable Medical Equipment	30%	50%

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GPMKHA21-IOWSGplanbk-0720