



2025 HMO 5000 Elite Silver

Member Benefits			Member Responsibility	
			Participating (In-Network)	Non-Participating (Out-of-Network (OON))
Plan Year Deductible Embedded	Medical	Individual	\$5,000	Not Applicable
		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.	
		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.	
		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 <i>30 day supply</i>		
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
<i>If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug</i>		
Maternity		
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.</i>		
Routine Prenatal Care	40%	Not Covered
Maternity Inpatient	40%	Not Covered
Newborn Care	40%	Not Covered
Pediatric Services <i>(members up to the age of 19 years old)</i>		
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		
<i>Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate screenings & more. Age/frequency schedules apply.</i>		
Wellness Care	*\$0	Not Covered
Other Services		
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>		
Other Covered Services	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.

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.