Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (Alliance)
Self-Funded Preferred Provider Organization (PPO)
Summary of Benefits

AS000068 Salary PPO / XR002679 **Self-Funded PPO**

AS000068 / XR002679

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$2,000 Self Only; $4,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$4,000 Self Only; $8,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	40%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$4,000 Self Only; $8,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$8,000 Self Only; $16,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	20% Coinsurance after deductible	40% Coinsurance after deductible	
Telehealth Visit	20% Coinsurance after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	20% Coinsurance after deductible	40% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Not Covered	Not Covered	
Chiropractic Services	Not Covered	Not Covered	
Allergy Treatment	20% Coinsurance after deductible	40% Coinsurance after deductible	
Allergy Injections	20% Coinsurance after deductible	40% Coinsurance after deductible	
Laboratory & Pathology	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	40% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	40% Coinsurance after deductible	
Dialysis	20% Coinsurance after deductible	40% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	20% Coinsurance after deductible	40% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	40% Coinsurance after deductible	
Ambulatory Surgical Center	20% Coinsurance after deductible	40% Coinsurance after deductible	
Professional Surgical and Related Services	20% Coinsurance after deductible	40% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	20% Coinsurance after In-Network Deductible		
Emergency Room Care	20% Coinsurance after In-Network Deductible		
Emergency Medical Transportation	20% Coinsurance after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	40% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	40% Coinsurance after deductible	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	Not Covered	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Postnatal Office Visits	20% Coinsurance after deductible	40% Coinsurance after deductible	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	20% Coinsurance after deductible	40% Coinsurance after deductible	
Other Services			
Home Health Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Does not include Rehabilitation Services; Unlimited.
Hospice Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network).
Skilled Nursing Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	40% Coinsurance after deductible	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids after deductible $689 Copay per Hearing Aid for Basic Technology Hearing Aids after deductible $989 Copay per Hearing Aid for Prime Technology Hearing Aids after deductible $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids after deductible $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids after deductible	Not Covered	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	20% Coinsurance after deductible	40% Coinsurance after deductible	May be rendered at home; Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	20% Coinsurance after deductible	40% Coinsurance after deductible	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	20% Coinsurance after deductible	40% Coinsurance after deductible	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy
Voluntary Termination of Pregnancy	See Outpatient Surgical Services	See Outpatient Surgical Services	During first trimester only. Limited to 1 within a 12 month period.
Temporomandibular Joint Disorder	20% Coinsurance after deductible	40% Coinsurance after deductible	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Generic Preventive Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply ; Deductible does not apply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Preferred Generic Drugs	20% Coinsurance after deductible		
Non-Preferred Generic Drugs	20% Coinsurance after deductible		
Preferred Brand Drugs	20% Coinsurance after deductible		
Non-Preferred Brand Drugs	20% Coinsurance after deductible		
Preferred Specialty Drugs	20% Coinsurance 30 day supply at Specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	20% Coinsurance 30 day supply at Specialty pharmacy only after deductible		

QHDHP Template Rev 01/2020

- In case of conflict between this summary and your Self-Funded PPO Benefit Guide, the terms and conditions of the Self-Funded PPO Benefit Guide will govern.
- This self-funded plan includes a network of health care providers through which services are covered at the In-Network level of benefits. If you receive covered services from a provider that is not part of the plan's network, benefits will be provided at the lower Out-of-Network benefit level.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after an emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Self-Funded PPO plans are administered by Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.