

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

## AS000066 PPO Minimum Value Plan / XR002033

Self-Funded PPO AS000066 / XR002033

Benefit Period  Calendar Year  Annual Deductible  Se,525 Individual; \$13,050 Family Se,525 Individual; \$13,0	Health Care Services	In-Network	Out-of-Network	Limitations		
Annual Deductible  \$ 9,5.25 Individual; \$13,050 Family  \$ 13,050 Individual; \$26,100 Family  \$ 13,050 Individual; \$26,100 Family  \$ 1,050 Individual; \$ 1,050 Family  \$ 1,050	Plan Attributes					
Annual Deductible \$6,525 Individual; \$13,050 Family Coinsurance 0% 40% Coinsurance 0% Annual Cut-6-Pocket Maximum N/A	Benefit Period	Calendar				
Annual Coinsurance Maximum  NA  NA  NA  NA  NA  Annual Coinsurance Maximum  NA  NA  NA  NA  NA  NA  NA  NA  NA  N	Annual Deductible	\$6,525 Individual; \$13,050 Family	\$13,050 Individual; \$26,100 Family	coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the		
Annual Out-of-Pocket Maximum \$6,525 Individual; \$13,050 Family N/A    N/A	Coinsurance	0%	40%			
Annual Out-of-Pocket Maximum  \$6,525 Individual; \$13,050 Family  N/A    Modern Cover, All Other Cover Stahring accumulates unless otherwise specified. In and Out-of-Network streets curless otherwise specified. In and Out-of-Network surless otherwise specified. In and Out-of-Network waximums accumulates separately. Out-of-Pocket Maximums accumulates separately. Provided	Annual Coinsurance Maximum	N/A	N/A			
Office Visit / Physical Exam / Weil Baby Exam Related Laboratory and Radiology Services Pap Smear, Mammogram, Tubal Ligation Immunizations Covered - Deductible does not apply Rot Covered Deductible does not apply Not Covered Not Covered  Covered - Deductible does not apply Not Covered  Dispatch & Physician Services Primary Care Office Visit Covered after deductible Routine Audiology Exam Covered after deductible Routine Audiology Exam Covered - Deductible does not apply Not Covered Routine Audiology Exam Covered after deductible Routine Audiology Exam Covered - Deductible does not apply Not Covered Routine Eye Exam Not Covered Not Cov	Annual Out-of-Pocket Maximum	\$6,525 Individual; \$13,050 Family	N/A	balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. In and Out-of-Network		
Exam Covered - Deductible does not apply Not Covered   Pap Smear, Mammogram, Tubal Ligation Covered - Deductible does not apply Not Covered   Pap Smear, Mammogram, Tubal Ligation Covered - Deductible does not apply Not Covered   Primary Care Office Visit Covered after deductible   Primary Care Office Visit Covered after deductible   Professional Stroke Specialist Office Visit   Professional Stroke Specialist Office Visit   Routine Audiology Exam   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Care Office Visit   Routine Eye Exam   Rout Covered   Primary Covered   Rout Cov	Preventive Services					
Pap Smear, Mammogram, Tubal Ligation Covered - Deductible does not apply Outpatient & Physician Services Primary Care Office Visit Covered after deductible Telehealth Visit Covered after deductible Covered after deductible Covered after deductible Covered after deductible Routine Specialist Office Visit Covered - Deductible does not apply Not Covered Through our contracted telehealth services provider.  Covered - Deductible does not apply Not Covered Routine Audiology Exam Covered - Deductible does not apply Not Covered Chiropractic Services Not Covered Not Covered Not Covered Not Covered Not Covered Chiropractic Services Not Covered Not Covered Not Covered Not Covered Covered - Deductible does not apply Not Covered Not Covered Not Covered Covered - Not Covered Not Covered Not Covered Not Covered Not Covered Covered - Deductible does not apply Not Covered Not Covered Not Covered Covered - Deductible does not apply Not Covered after deductible Not Coinsurance after deductible Not	Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered			
Immunizations   Covered - Deductible does not apply   Not Covered	Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered			
Covered after deductible   A0% Coinsurance after deductible   Not Covered provider.	Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered			
Primary Care Office Visit Covered after deductible Covered - Deductible does not apply Routine Audiology Exam Covered - Deductible does not apply Routine Sye Exam Not Covered Allergy Treatment Covered after deductible Allergy Injections Covered - Deductible does not apply May Coinsurance after deductible Covered after deductible Allergy Injections Covered - Deductible does not apply May Coinsurance after deductible Covered after deductible Allergy Injections Covered after deductible Allergy Injections Covered - Deductible does not apply Allergy Injections Covered after deductible Allergy Injections Allergy Injections Covered after deductible Allergy Injections Allergy Injections Allergy Injections Covered after deductible Allergy Injections Allergy Inject	Immunizations	Covered - Deductible does not apply	Not Covered			
Telehealth Visit  Covered after deductible  Not Covered  Through our contracted telehealth services provider.  Specialist Office Visit  Covered - Deductible does not apply  Not Covered  Not Covisurance after deductible  Not Coinsurance after	Outpatient & Physician Services					
Specialist Office Visit  Covered after deductible  Covered after deductible  Covered after deductible  Covered after deductible  Covered - Deductible does not apply  Not Covered  Not Covered  Not Covered  Not Covered  Chiropractic Services  Not Covered  Not Covered after deductible  Not Covered after deductibl	Primary Care Office Visit	Covered after deductible	40% Coinsurance after deductible			
Routine Audiology Exam  Routine Eye Exam  Not Covered - Deductible does not apply  Routine Eye Exam  Not Covered - Not Covered	Telehealth Visit	Covered after deductible	Not Covered			
Routine Eye Exam Not Covered Not Covered Not Covered Not Covered Chiropractic Services Not Covered Not	Specialist Office Visit	Covered after deductible	40% Coinsurance after deductible			
Chiropractic Services Not Covered Medical Programment Covered after deductible A0% Coinsurance afte	Routine Audiology Exam	Covered - Deductible does not apply	Not Covered			
Allergy Treatment Covered after deductible Allergy Injections Covered - Deductible does not apply Allergy Reathology Covered after deductible Allergy Reathology Covered after In-Network Deductible Emergency Room Care Covered after In-Network Deductible Emergency Redical Transportation Covered after In-Network Deductible Emergency Redical Transportation Covered after In-Network Deductible Emergency Redical Transportation Covered after deductible Allergy Reathology Reath	Routine Eye Exam	Not Covered	Not Covered			
Allergy Injections Covered - Deductible does not apply Laboratory & Pathology Covered - Deductible does not apply Covered - Deductible does not apply 40% Coinsurance after deductible Some services require preauthorization. Services require preauthorization. Services require preauthorization.  Services require preauthorization. Some services require preauthorization.  Out-of-Network benefits are not covered unless prior Authorized.  Out-of-Network benefits are not covered after deduct	Chiropractic Services	Not Covered	Not Covered			
Laboratory & Pathology  Covered - Deductible does not apply Imaging MRI, CT & PET Scans  Covered after deductible Ad% Coinsurance after deductible Ad% Coinsurance after deductible Services require preauthorization.  Covered after deductible Ad% Coinsurance after deductible Some services require preauthorization.  Covered after deductible Ad% Coinsurance after deductible Covered after deductible Dialysis Covered after deductible After Covered after Deductible Emergency/Urgent Care Urgent Care Urgent Care Covered after In-Network Deductible Emergency Room Care Emergency Medical Transportation Covered after In-Network Deductible Emergency Medical Transportation Covered after Deductible After Deductible Emergency Reductions After Deductible After Deductible Emergency Reductible After Deductible After D	Allergy Treatment	Covered after deductible	40% Coinsurance after deductible			
Imaging MRI, CT & PET Scans  Covered after deductible  A0% Coinsurance after deductible  Dialysis  Covered after deductible  Covered after deductible  Out-of-Network benefits are not covered unless Prior Authorized.  Outpatient Medical Drugs  Covered after deductible  Outpatient Surgical Services  Outpatient Surgical Services  Outpatient Surgical Center  Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  Covered after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  Emergency/Urgent Care  Urgent Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after deductible  A0% Coinsurance after deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Services  Facility Fee  Covered after deductible  A0% Coinsurance after deductible	Allergy Injections	Covered - Deductible does not apply	40% Coinsurance after deductible			
Radiology (X-ray)  Covered after deductible  Radiation Therapy & Chemotherapy  Covered after deductible  Covered after deductible  Dialysis  Covered after deductible  Anow Coinsurance after deductible  Covered after deductible  Anow Coinsurance after deductible  Covered after deductible  Anow Coinsurance after deductible  Covered after deductible  Covered after In-Network Deductible  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after deductible  Covered after In-Network Deductible  Emergency Medical Services  Facility Fee  Covered after deductible  Covered after deductible  Anow Coinsurance after deductible	Laboratory & Pathology	Covered - Deductible does not apply	40% Coinsurance after deductible	Some services require preauthorization.		
Radiation Therapy & Chemotherapy  Covered after deductible  Dialysis  Covered after deductible  Outpatient Medical Drugs  Covered after deductible  Outpatient Surgical Services  Covered after deductible  Ambulatory Surgical Center  Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  Foressional Surgical and Related Services  Covered after deductible  Covered after In-Network Deductible  Emergency/Urgent Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Services  Facility Fee  Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  40% Coinsurance after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  Covered after deductible  A0% Coinsurance after deductible	Imaging MRI, CT & PET Scans		40% Coinsurance after deductible			
Radiation Therapy & Chemotherapy  Covered after deductible  Dialysis  Covered after deductible  Outpatient Medical Drugs  Covered after deductible  Outpatient Surgical Services  Covered after deductible  Ambulatory Surgical Center  Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  Foressional Surgical and Related Services  Covered after deductible  Covered after In-Network Deductible  Emergency/Urgent Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Services  Facility Fee  Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  40% Coinsurance after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  A0% Coinsurance after deductible  Covered after deductible  A0% Coinsurance after deductible	5 5	Covered after deductible	40% Coinsurance after deductible			
Dialysis  Covered after deductible  40% Coinsurance after deductible  Out-of-Network benefits are not covered unless Prior Authorized.  Outpatient Medical Drugs  Covered after deductible  Outpatient Surgical Services  Outpatient Surgery  Covered after deductible  Ambulatory Surgical Center  Covered after deductible  After deductible  Covered after deductible  After deductible  Covered after deductible  After deductible  Covered after deductible  Covered after deductible  Emergency/Urgent Care  Urgent Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Services  Facility Fee  Covered after deductible  After Deductible  After Deductible  Emergency Account A		Covered after deductible	40% Coinsurance after deductible			
Outpatient Surgical Services Outpatient Surgery Covered after deductible 40% Coinsurance after deductible Ambulatory Surgical Center Covered after deductible 40% Coinsurance after deductible Professional Surgical and Related Services Covered after deductible 40% Coinsurance after deductible Emergency/Urgent Care Urgent Care Covered after In-Network Deductible Emergency Room Care Covered after In-Network Deductible Emergency Medical Transportation Covered after In-Network Deductible Emergency Medical Transportation Covered after In-Network Deductible Emergency Transport only.  Inpatient Hospital Services Facility Fee Covered after deductible 40% Coinsurance after deductible Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible 40% Coinsurance after deductible 40% Coinsurance after deductible	Dialysis					
Outpatient Surgery Outpatient Surgery Covered after deductible Ambulatory Surgical Center Covered after deductible Professional Surgical and Related Services Covered after deductible  Covered after deductible  40% Coinsurance after deductible  Emergency/Urgent Care Urgent Care Covered after In-Network Deductible  Emergency Room Care Covered after In-Network Deductible  Emergency Medical Transportation Covered after In-Network Deductible  Emergency Medical Transportation Covered after In-Network Deductible  Emergency Medical Transportation Covered after In-Network Deductible  Emergency Alega Services  Facility Fee Covered after deductible  Covered after deductible  A0% Coinsurance after deductible  40% Coinsurance after deductible  A0% Coinsurance after deductible	Outpatient Medical Drugs	Covered after deductible	40% Coinsurance after deductible			
Ambulatory Surgical Center Covered after deductible Professional Surgical and Related Services Covered after deductible  Emergency/Urgent Care Urgent Care Covered after In-Network Deductible Emergency Room Care Covered after In-Network Deductible Emergency Medical Transportation Covered after In-Network Deductible Emergency transport only.  Inpatient Hospital Services Facility Fee Covered after deductible Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies Covered after deductible A0% Coinsurance after deductible A0% Coinsurance after deductible	Outpatient Surgical Services					
Professional Surgical and Related Services	Outpatient Surgery	Covered after deductible	40% Coinsurance after deductible			
Professional Surgical and Related Services		Covered after deductible	40% Coinsurance after deductible			
Emergency/Urgent Care  Urgent Care  Covered after In-Network Deductible  Emergency Room Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency transport only.  Inpatient Hospital Services  Facility Fee  Covered after deductible  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible  40% Coinsurance after deductible  40% Coinsurance after deductible	, ,	Covered after deductible	40% Coinsurance after deductible			
Urgent Care Covered after In-Network Deductible Emergency Room Care Covered after In-Network Deductible Emergency Medical Transportation Covered after In-Network Deductible Emergency transport only.  Inpatient Hospital Services Facility Fee Covered after deductible 40% Coinsurance after deductible Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible 40% Coinsurance after deductible A0% Coinsurance after deductible	5	-				
Emergency Room Care  Covered after In-Network Deductible  Emergency Medical Transportation  Covered after In-Network Deductible  Emergency transport only.  Inpatient Hospital Services  Facility Fee  Covered after deductible  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible  Covered after deductible  40% Coinsurance after deductible  40% Coinsurance after deductible		Covered after In-Net	work Deductible			
Emergency Medical Transportation  Covered after In-Network Deductible  Emergency transport only.  Inpatient Hospital Services  Facility Fee  Covered after deductible  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible  Covered after deductible  40% Coinsurance after deductible  40% Coinsurance after deductible		Covered after In-Network Deductible				
Inpatient Hospital Services Facility Fee Covered after deductible 40% Coinsurance after deductible Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies Covered after deductible 40% Coinsurance after deductible		Covered after In-Network Deductible		Emergency transport only.		
Facility Fee Covered after deductible 40% Coinsurance after deductible  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible 40% Coinsurance after deductible	Inpatient Hospital Services					
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies  Covered after deductible 40% Coinsurance after deductible and Supplies	-	Covered after deductible	40% Coinsurance after deductible			
	Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies					
Bariatric Surgery and Related Services Covered after deductible Not Covered One procedure per lifetime	Bariatric Surgery and Related Services	Covered 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	Covered 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	Covered after deductible	40% Coinsurance after deductible				
Other Services						
Home Health Care	Covered after deductible	40% Coinsurance after deductible	Does not include Rehabilitation Services; Unlimited.			
Hospice Care	Covered after deductible	40% Coinsurance after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network).			
Skilled Nursing Care	Covered after deductible	40% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).			
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	40% Coinsurance after deductible	Covered for approved equipment only.			
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered 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	Covered 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	Covered 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	Not Covered	Not Covered				
Pharmacy (Affiliated pharmacy providers	only)					
Preferred Generic Drugs	Covered after deductible		A 90-day supply of non-maintenance drugs must			
Non-Preferred Generic Drugs	Covered after deductible		be filled at our designated mail order pharmacy.			
Preferred Brand Drugs	Covered after deductible		Other exclusions & limitations may apply.			
Non-Preferred Brand Drugs	Covered after deductible		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 Specialty Drugs	Covered 30 day supply at Specialty pharmacy only after deductible					
Non-Preferred Specialty Drugs	Covered 30 day supply at Specialty pharmacy only after deductible					

## 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.