Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (AHLIC) Self-Funded-HMO
Summary of Benefits

AS000070/XR002039

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$500 Individual; $1,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	$500 Individual; $1,000 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and copays.
Annual Out-of-Pocket Maximum	$6,850 Individual; $13,700 Family	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay – Deductible does not apply	N/A	
Telehealth Visit	$20 Copay – Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay – Deductible does not apply	N/A	
Audiology Office Visit	$40 Copay – Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share.
Eye Exam Office Visit	Not Covered	N/A	Covers Medical Services Only
Allergy Treatment	20% Coinsurance after deductible	N/A	
Allergy Injections	20% Coinsurance after deductible	N/A	
Laboratory & Pathology	Covered – Deductible does not apply	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	N/A	Services require preauthorization
Radiology (X-ray)	20% Coinsurance after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	N/A	
Dialysis	20% Coinsurance after deductible	N/A	
Chiropractic Services	$20 Copay – Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 24 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$25 Copay – Deductible does not apply		
Emergency Room Care	$100 Copay – Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay– Deductible does not apply		Emergency transport only
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services.
Postnatal Office Visits	Covered - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	20% Coinsurance after deductible	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	Covered – Deductible does not apply for days 1-45 20% Coinsurance after deductible for day 46 and greater	N/A	
Outpatient Services	Covered – Deductible does not apply for visits 1-20 $20 Copay – Deductible does not apply for visits 21 and greater	N/A	
Other Services			
Home Health Care	20% Coinsurance after deductible	N/A	Unlimited. Does not include Rehabilitation Services.
Hospice Care	20% Coinsurance after deductible	N/A	Unlimited
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Covered for authorized services; Up to 120 days per benefit year.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	N/A	Covered for approved equipment only. See rider for detailed information.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids $689 Copay per Hearing Aid for Basic Technology Hearing Aids $989 Copay per Hearing Aid for Prime Technology Hearing Aids $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Not Covered	N/A	
Rehabilitation Services: Physical, Occupational, and Speech Therapy	20% Coinsurance after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	20% Coinsurance after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Termination of Pregnancy	20% Coinsurance after deductible	N/A	Once per twelve months.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Not Covered	N/A	
Assisted Reproductive Technologies	Not Covered	N/A	
Temporomandibular Joint Disorder	20% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 34-day supply, $20 Copay 90-day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Infertility prescription drugs are not covered. Other exclusions & limitations may apply. See rider for detailed information.
Non-Preferred Generic Drugs	$10 Copay 34-day supply, $20 Copay 90-day supply		
Preferred Brand Drugs	$25 Copay 34-day supply, $50 Copay 90-day supply		
Non-Preferred Brand Drugs	$35 Copay 34-day supply, $70 Copay 90-day supply		
Preferred Specialty Drugs	$75 Copay 34-day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$75 Copay 34-day supply at specialty pharmacy only		

Benefit Riders: HS0001, HS000T, HS0012, HS0014, HS0059, HS0068, HS0078, HS0093, HS0094, HS0095, HS0096, HS0097, HS0099, HS0151, HS0101, HS0138, XMHP, HS0103

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- In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern.
-Elective hospital admissions require that AHLIC be notified prior to the admission. Failure to notify AHLIC within 48 hours could result in a reduction of benefits, or nonpayment.
- Students away at school are covered for acute illness and injury related services according to AHLIC criteria.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.