Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan

Alliance Health and Life Insurance Company (AHLIC) Self-Funded-HMO HDHP

Summary of Benefits **AS000073 XR002385**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,500 Individual; $3,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amount.	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	N/A	N/A	
Annual Out-of-Pocket Maximum	$3,000 Individual; $6,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amount.	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% Coinsurance after deductible	N/A	
Telehealth Visit	20% Coinsurance after deductible	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	20% Coinsurance after deductible	N/A	
Audiology Office Visit	20% Coinsurance after deductible	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	20% Coinsurance after deductible	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% Coinsurance after deductible	N/A	Manipulation of the spine for subluxation only; Up to 12 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	20% Coinsurance after deductible		
Emergency Room Care	20% Coinsurance after deductible		
Emergency Medical Transportation	20% Coinsurance after deductible		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	20% Coinsurance after deductible	N/A	
Labor Delivery and Newborn Care	20% Coinsurance after deductible	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	20% Coinsurance after deductible	N/A	
Outpatient Services	20% Coinsurance after deductible	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	Up to 210 days per benefit year.
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 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 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	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)			
Generic Preventive for Statins, High Blood Pressure, Smoking deterrents and Osteoporosis	$10 Copay for 30-day supply; $20 Copay for 90-day supply- Deductible does not apply		
Preferred Generic Drugs	20% Coinsurance after deductible 30 and 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	20% Coinsurance after deductible 30 and 90-day supply		
Preferred Brand Drugs	20% Coinsurance after deductible 30 and 90-day supply		
Non-Preferred Brand Drugs	20% Coinsurance after deductible 30 and 90-day supply		
Preferred Specialty Drugs	20% Coinsurance after deductible 30 and 90-day supply		
Non-Preferred Specialty Drugs	20% Coinsurance after deductible 30 and 90-day supply		

QHDHP

BENEFIT RIDERS: HS0001, HS000T, HS0014, HS0078, HS0151, HS0101, HS0105, HS0106, HS0111, HS0134, HS0138, X140, X141, X142, XMHP, HS0108

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- 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.
- In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.