Alliance Health and Life Insurance Company

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

Summary of Benefits **AS000068/ XR002386**

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 collectedly meet the family coverage amount.	$3,000 Individual; $6,000 Family If more than one person is covered under the plan, all family members must collectedly meet the family coverage amount.	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	$3,000 Individual; $6,000 Family If more than one person is covered under the plan, all family members must collectedly meet the family coverage amount.	$6,000 Individual; $12,000 Family If more than one person is covered under the plan, all family members must collectedly meet the family coverage amount.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates. 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	
Audiology Office Visit	20% Coinsurance after deductible	40% Coinsurance after deductible	One routine hearing exam per benefit period at no cost share (In-Network only).
Eye Exam Office Visit	Not Covered	Not Covered	Covers Medical Services Only
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.
Chiropractic Services	Not Covered	Not Covered	
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 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	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	20% Coinsurance after deductible	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	Unlimited; does not include Rehabilitation Services.
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	Covered for authorized services; 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. 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	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.
Vision Hardware	Not Covered	Not Covered	
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 and Out-of-Network),
Habilitation Services	20% Coinsurance after deductible	40% Coinsurance after deductible	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	40% Coinsurance after deductible	Once per twelve months
Voluntary Sterilizations	See Outpatient Surgical Services	40% Coinsurance after deductible	Limited to vasectomy
Infertility Services	Not Covered	Not Covered	
Assisted Reproductive Technologies	Not Covered	Not Covered	
Temporomandibular Joint Disorder	Not Covered	Not Covered	
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 for 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 for 30 and 90-day supply		
Preferred Brand Drugs	20% Coinsurance after deductible for 30 and 90-day supply		
Non-Preferred Brand Drugs	20% Coinsurance after deductible for 30 and 90-day supply		
Preferred Specialty Drugs	20% Coinsurance after deductible, 30-day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	20% Coinsurance after deductible, 30-day supply at specialty pharmacy only		

QHDHP

BENEFIT RIDERS: AS0001, AS0003, AS000T, AS0118, AS0052, AS0053, AS0055, AS0057, A0106, AS0107, AS0116, AST3, X00P, X140, X141, X142, XMHP, AS0062

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- In cases of conflict between this summary and your Self-Funded Benefit Guide and Riders, the terms and conditions of the Self-Funded Benefit Guide and Riders will govern. This 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, they will be processed at the lower Out-of-Network benefit level.
- Elective hospital admissions require that AHLIC be notified prior to the admission. AHLIC must be notified within 48 hours of any emergency hospital admission. Failure to notify AHLIC could result in a reduction of benefits, or nonpayment.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.