Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan

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

Summary of Benefits **AS000071 XR002038**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$6,525 Individual; $13,050 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$6,525 Individual; $13,050 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	Covered after deductible	N/A	
Telehealth Visit	Covered after deductible	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	Covered after deductible	N/A	
Audiology Office Visit	Covered 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	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered – Deductible does not apply	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Chiropractic Services	Not Covered	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	Covered after deductible		
Emergency Room Care	Covered after deductible		
Emergency Medical Transportation	Covered after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered 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 after deductible	N/A	
Labor Delivery and Newborn Care	Covered after deductible	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	Covered after deductible	N/A	
Outpatient Services	Covered after deductible	N/A	
Other Services			
Home Health Care	Covered after deductible	N/A	Unlimited. Does not include Rehabilitation Services.
Hospice Care	Covered after deductible	N/A	Up to 210 days per benefit year
Skilled Nursing Care	Covered after deductible	N/A	Covered for authorized services; Up to 100 days per benefit year.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	N/A	Covered for approved equipment only. See rider for detailed information.
Hearing Aid Hardware	Not Covered	N/A	
Vision Hardware	Not Covered	N/A	
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	Covered 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	Covered 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	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	Covered 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. Other exclusions & limitations may apply. Infertility prescription drugs are not covered.
Non-Preferred Generic Drugs	Covered after deductible for 30 and 90-day supply		
Preferred Brand Drugs	Covered after deductible for 30 and 90-day supply		
Non-Preferred Brand Drugs	Covered after deductible for 30 and 90-day supply		
Preferred Specialty Drugs	Covered after deductible,30-day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	Covered after deductible, 30-day supply at specialty pharmacy only		

Benefit Riders: HS0001, HS000T, HS0014, HS0078, HS0101, HS0106, HS0109, HS0112, HS0138, X101, X102, X103, HS0110

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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.