Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (Alliance)
Self-Funded Preferred Provider Organization (PPO)
Summary of Benefits
AS000067 HOURLY PPO / XR002481 **Self-Funded PPO**

AS000067 / XR002481

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,500 Individual; $3,000 Family	$2,500 Individual; $5,000 Family	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	30%	40%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	$1,250 Individual; $2,500 Family	N/A	These values do not accumulate: premiums, balance-billed charges, penalties, deductibles, services with 50% coinsurance, copays, and health care this plan doesn't cover. In and Out-of-Network Coinsurance Maximums accumulate separately.
Annual Out-of-Pocket Maximum	$6,000 Individual; $12,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. 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	40% Coinsurance after deductible	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	40% Coinsurance after deductible	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	40% Coinsurance after deductible	
Immunizations	Covered - Deductible does not apply	40% Coinsurance after deductible	
Outpatient & Physician Services			
Primary Care Office Visit	$40 Copay - Deductible does not apply	40% Coinsurance after deductible	
Telehealth Visit	$15 Copay - Deductible does not apply	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$55 Copay - Deductible does not apply	40% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	40% Coinsurance after deductible	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Not Covered	Not Covered	
Chiropractic Services	Not Covered	Not Covered	
Allergy Treatment	30% Coinsurance after deductible	40% Coinsurance after deductible	
Allergy Injections	Covered - Deductible does not apply	40% Coinsurance after deductible	
Laboratory & Pathology	Covered - Deductible does not apply	40% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	30% Coinsurance after deductible	40% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	30% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	30% Coinsurance after deductible	40% Coinsurance after deductible	
Dialysis	30% Coinsurance after deductible	40% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	30% Coinsurance after deductible	40% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	30% Coinsurance after deductible	40% Coinsurance after deductible	
Ambulatory Surgical Center	30% Coinsurance after deductible	40% Coinsurance after deductible	
Professional Surgical and Related Services	30% Coinsurance after deductible	40% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	$70 Copay - Deductible does not apply		
Emergency Room Care	$150 Copay - Deductible does not apply		Copay will be waived if admitted 30% coinsurance after In-network deductible on Emergency Physician & Professional services
Emergency Medical Transportation	30% Coinsurance after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	30% Coinsurance after deductible	40% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	30% Coinsurance after deductible	40% Coinsurance after deductible	
Bariatric Surgery and Related Services	30% Coinsurance after deductible	Not Covered	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	40% Coinsurance after deductible	Covered under Preventive Services
Postnatal Office Visits	Covered - Deductible does not apply	40% Coinsurance after deductible	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	Covered – Deductible does not apply for days 1-45 30% Coinsurance after deductible for days 46 and greater	40% Coinsurance after deductible	
Outpatient Services	Covered – Deductible does not apply for visits 1-20 $40 Copay - Deductible does not apply for visits 21 and greater	40% Coinsurance after deductible	
Other Services			
Home Health Care	30% Coinsurance after deductible	40% Coinsurance after deductible	Does not include Rehabilitation Services; Unlimited.
Hospice Care	30% Coinsurance after deductible	40% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	30% Coinsurance after deductible	40% Coinsurance after deductible	Up to 120 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	30% Coinsurance after deductible	40% Coinsurance after deductible	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids - Deductible does not apply $689 Copay per Hearing Aid for Basic Technology Hearing Aids - Deductible does not apply $989 Copay per Hearing Aid for Prime Technology Hearing Aids - Deductible does not apply $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids - Deductible does not apply $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids - Deductible does not apply	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.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	30% Coinsurance 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	30% Coinsurance 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	$40 Copay - Deductible does not apply	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	$20 Copay 34 day supply, $40 Copay 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. 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.
Non-Preferred Generic Drugs	$20 Copay 34 day supply, $40 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 34 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 34 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	$100 Copay 34 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$200 Copay 34 day supply at specialty pharmacy only		

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.