Alliance Health and Life Insurance Company
Exclusive Provider Organization (EPO)
Summary of Benefits

EPO

PP000NEW / XR000NEW QR-23056 ALTERNATE #1

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	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$3,000 Individual; $6,000 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.
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	$30 Copay - Deductible does not apply	N/A	
Telehealth Visit	$30 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	$40 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	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	
Outpatient Surgery	Covered after deductible	N/A	
Chiropractic Services	$40 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period
Emergency/Urgent Care			
Urgent Care	$40 Copay - Deductible does not apply		
Emergency Room Care	$150 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered - Deductible does not apply		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	$1,000 Copay 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	$40 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Abuse Services			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$30 Copay - Deductible does not apply	N/A	

Other Services			
Home Health Care	Covered after deductible	N/A	Does not include Rehabilitation Services; Up to 100 visits per benefit period.
Hospice Care	Covered after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	Covered after deductible	N/A	Up to 100 days per benefit period
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after deductible	N/A	Covered for approved equipment only
Hearing Aid Hardware	Covered after deductible	N/A	Covered for authorized equipment only
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	May be rendered at home; Up to 60 combined visits per benefit period
Habilitation Services	$40 Copay - Deductible does not apply	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 cost ABA sharing amount.
Voluntary Sterilizations	Covered after deductible	N/A	Limited to vasectomy
Infertility Services	Covered after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered after deductible	N/A	1 attempt per lifetime
Temporomandibular Joint Disorder	Not Covered	N/A	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 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.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply		
Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only		

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Benefit Riders: A00T,A00P,AMHE,ABAR,A536,A479,A459,A303,A235,A174,A156,A152,A104,A013,A678

- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours of any emergency hospital admission. Failure to notify Alliance 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.
- EPO plans are offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.