Alliance Health and Life Insurance Company

Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)
Summary of Benefits
PP001399 / XR001668 **PPO**

PP001399 / XR001668

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$500 Individual; $1,000 Family	$1,000 Individual; $2,000 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	0%	20%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	$2,000 Individual ; $4,000 Family	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	$3,000 Individual; $6,000 Family	$6,000 Individual; $12,000 Family	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	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	$30 Copay - Deductible does not apply	20% Coinsurance after deductible	
Telehealth Visit	$30 Copay - Deductible does not apply	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay - Deductible does not apply	20% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$40 Copay - Deductible does not apply	20% Coinsurance after deductible	Manipulation of the spine for subluxation only. Up to 20 visits per benefit period (Combined In and Out-of-Network).
Allergy Treatment	Covered after deductible	20% Coinsurance after deductible	
Allergy Injections	Covered after deductible	20% Coinsurance after deductible	
Laboratory & Pathology	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	20% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	20% Coinsurance after deductible	
Dialysis	Covered after deductible	20% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	Covered after deductible	20% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	20% Coinsurance after deductible	
Ambulatory Surgical Center	Covered after deductible	20% Coinsurance after deductible	
Professional Surgical and Related Services	Covered after deductible	20% Coinsurance after deductible	
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	20% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	20% Coinsurance after deductible	
Bariatric Surgery and Related Services	Not Covered	Not Covered	

Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	Covered - Deductible does not apply	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	$30 Copay - Deductible does not apply	20% Coinsurance after deductible	
Other Services			
Home Health Care	Covered after deductible	20% Coinsurance after deductible	Does not include Rehabilitation Services. Up to 100 visits per benefit period (Combined In and Out-of-Network).
Hospice Care	Covered after deductible	20% Coinsurance after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network).
Skilled Nursing Care	Covered after deductible	20% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	20% 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	$40 Copay - Deductible does not apply	20% 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	Covered - Deductible does not apply	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered - Deductible does not apply	Not Covered	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
Infertility Services	Covered after deductible	20% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered after deductible	20% Coinsurance after deductible	One attempt per lifetime
Temporomandibular Joint Disorder	Covered after deductible	20% Coinsurance after deductible	Coverage for non-invasive treatments only.
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. 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	$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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- In case of conflict between this summary and your PPO Group Health Insurance Policy and Riders, the terms and conditions of the PPO Group Health Insurance Policy 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 Alliance be notified prior to the admission. Alliance must be notified within 48 hours after any 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.
- PPO plans are offered through Alliance health and Life Insurance Company, a wholly owned subsidiary of health Alliance Plan.
-For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.