ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
HIGH DEDUCTIBLE HEALTH PLAN PREFERRED PROVIDER ORGANIZATION (HDHP PPO)
SCHEDULE OF BENEFITS

rev 7/15/15

This Summary of Benefits is designed to provide an overview of the Alliance High Deductible Health Plan PPO and is subject to the terms and conditions of the actual policy. In cases of conflict between this summary and the policy, the terms and conditions of the policy govern. This program features a network of health care providers through which the Subscriber and Dependents can receive services at the In-Network level of benefits. Alliance High Deductible Health Plan PPO Subscribers and Dependents who do not seek services from a network provider, or who are not directed through a referral authorization by a network provider, will receive services at the **lower Out-of-Network benefit level**. Dependents who are Students Away at School may receive select services at the in-network level of coverage with prior authorization from the HAP/AHL Student Coordinator who may be contacted at (313) 664-8950. Services that do not receive prior authorization will be covered at the Out-of–Network level of coverage.

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	Calendar year		
Annual Deductible	$3,000 Self-only ; $6,000 Family Not to exceed $4,000 from any one person	$6,000 Self-only ; $12,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductibles do not include copays. In and Out-of-Network deductibles accumulate separately.
Coinsurance Percentage	20%	40%	Coinsurance applies towards the Annual Out-of-Pocket Maximum.
Annual Out-of-Pocket Maximum	$4,000 Self-only ; $8,000 Family Not to exceed $4,000 from any one person	$8,000 Self-only ; $16,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Annual Out-of-Pocket Maximums include deductibles, coinsurance, and copays. These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. In and Out-of-Network annual Out-of-Pocket Maximums accumulate separately.
Preventive Services	**(No annual dollar limit)**		Preventive Services are not subject to the deductible
Preventive Office Visit	Covered	Not Covered	
Periodic Physical Exam Office Visit	Covered	Not Covered	
Well Baby Office Visit	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exam Office Visit	Covered	Not Covered	
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	
Outpatient & Physician Services			
Personal Care Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	
Gynecology Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	
Allergy Testing and Injections	Plan pays 80% after deductible	Plan pays 60% after deductible	
Other Injections	Plan pays 80% after deductible	Plan pays 60% after deductible	
Labs Tests & X-Rays	Plan pays 80% after deductible	Plan pays 60% after deductible	*****Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a denial in charges.
Dialysis	Plan pays 80% after deductible	Plan pays 60% after deductible	
Chiropractic Visit & Related Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Manipulation of the spine for subluxation only - 20 visits per benefit year
Outpatient Surgery & Related Svc	Plan pays 80% after deductible	Plan pays 60% after deductible	*****Some services require prior authorization
Radiation/Chemotherapy	Plan pays 80% after deductible	Plan pays 60% after deductible	
Eye Exam Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	
Audiology Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	
Emergency Services			
Emergency Room Services	Plan pays 80% after deductible		
Urgent Care Facility Services	Plan pays 80% after deductible		
Emergency Ambulance Services	Plan pays 80% after deductible		Emergency transport only
Inpatient Hospital Services			Unlimited days of care ******Admissions require Alliance be notified within 48 hours of admission. Failure to notify Alliance within 48 hours could result in a denial of charges.
Semi-Private Room	Plan pays 80% after deductible	Plan pays 60% after deductible	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Plan pays 80% after deductible	Plan pays 60% after deductible	
Related Therapy Services	Plan pays 80% after deductible	Plan pays 60% after deductible	
Surgery and Related Services	Plan pays 80% after deductible	Plan pays 60% after deductible	******Some services require prior authorization
Related Lab Tests and X-Rays	Plan pays 80% after deductible	Plan pays 60% after deductible	
Physician/Professional Services	Plan pays 80% after deductible	Plan pays 60% after deductible	
Riders			**00P,172,479,MHE,X140,X141,X142,369,NEW: $3K/$6K DED, 20% COINS, $4K/$8K OOP MAX INN - HSA (Aggregate w/Cap Deductible, Embedded OOPM,NEW: $6K/$12K DED, 40% COINS, $8K/$16K OOP MAX OON- HSA (Aggregate Deductible, Aggregate OOPM**

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Maternity Services			
Outpatient Prenatal Visits	Covered	Not Covered	Covered as Preventive Services. Not covered Out-of-Network
Outpatient Postnatal Visits	Plan pays 80% after deductible	Plan pays 60% after deductible	
Labor, Delivery and Newborn Care	Plan pays 80% after deductible	Plan pays 60% after deductible	**Some services require prior authorization
Ancillary Services			
Home Health Care	Plan pays 80% after deductible	Plan pays 60% after deductible	The number of visits for Medically Necessary home health care shall not exceed 100 visits per Benefit Period. (Combined In and Out-of-Network) Does not include PT/OT/ST. See PT/OT/ST coverage.
Hospice Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network)
Rehabilitation Services Physical, Occupational and Speech Therapy	Plan pays 80% after deductible	Plan pays 60% after deductible	Up to 60 combined visits per benefit year-May be rendered at home (Combined In and Out-of-Network)
Habilitation Services	Plan pays 80% after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
Durable Medical Equipment (DME)	Plan pays 80% after deductible	Plan pays 60% after deductible	Must be an approved piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Plan pays 80% after deductible	Plan pays 60% after deductible	Must be an approved piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Up to 100 days per benefit year (Combined In and Out-of-Network)
Mental/Behavioral Health Services			Services can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755
Inpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible	**Some services require prior authorization
Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Covered as medically necessary
Substance Use Disorder Services			Services can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755
Inpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible	**Some services require prior authorization
Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Covered as medically necessary
Transplant Services			*Some services require prior authorization
Organ Transplant and Related Services	Plan pays 80% after deductible	Not Covered	
Other Services			
Prescription Drugs	After the deductible is satisfied the following Copays apply - $10 Copay per Generic; $60 Copay per Preferred Brand-Name; $60 Copay per Non Preferred Brand-Name	Not Covered	Following applies after Deductible: Does not include coverage of drugs for Infertility or Obesity. All prescriptions must meet Alliance guidelines. Retail: 30 day supply for non-maintenance drugs at 1 Copay. 90 day supply for eligible maintenance drugs at 2 Copays. Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays. Specialty Drugs are not available at 90 day or Mail Order.
Voluntary Termination of Pregnancy	Plan pays 80% after deductible	Plan pays 60% after deductible	Voluntary abortions performed during first trimester only. Limited to 1 episode within a 24 month period.
Voluntary Sterilization	Women: Covered Men: Plan pays 80% after deductible	Women: Not Covered Men: Plan pays 60% after deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Services**