Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)

Summary of Benefits

HAP PPO Gold 1200 **PPO**

PPQ00053 / XRQ00121

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,200 Individual; $2,400 Family	$3,000 Individual; $6,000 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%	50%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
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	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	50% Coinsurance after deductible	
Telehealth Visit	Covered - Deductible does not apply	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$60 Copay - Deductible does not apply	50% Coinsurance after deductible	
Audiology Office Visit	$60 Copay - Deductible does not apply	50% Coinsurance after deductible	One routine hearing exam per benefit period at no cost share. Routine exam not covered Out-of-Network.
Eye Exam Office Visit	$60 Copay - Deductible does not apply	50% Coinsurance after deductible	One routine eye exam per benefit period at no cost share. Routine exam not covered Out-of-Network.
Chiropractic Services	$30 Copay - Deductible does not apply	50% Coinsurance after deductible	Manipulation of spine for subluxation only.; Up to 20 visits per benefit period (Combined In and Out-of-Network).
Allergy Treatment	Covered after deductible	50% Coinsurance after deductible	
Allergy Injections	Covered after deductible	50% Coinsurance after deductible	
Laboratory & Pathology	$45 Copay - Deductible does not apply	50% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	50% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	$45 Copay - Deductible does not apply	50% Coinsurance after deductible	
Radiation Therapy & Chemotherapy	Covered after deductible	50% Coinsurance after deductible	
Dialysis	Covered after deductible	50% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	50% Coinsurance after deductible	
Ambulatory Surgical Center	Covered after deductible	50% Coinsurance after deductible	
Professional Surgical and Related Services	Covered after deductible	50% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	$65 Copay - Deductible does not apply		
Emergency Room Care	$300 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay - Deductible does not apply		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	50% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	50% Coinsurance after deductible	
Bariatric Surgery and Related Services	Covered after deductible	Not Covered	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Postnatal Office Visits	$60 Copay - Deductible does not apply	50% Coinsurance after deductible	
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	50% Coinsurance after deductible	OON Benefits do not apply to ABA.
Other Services			
Home Health Care	Covered after deductible	50% Coinsurance after deductible	Does not include Rehabilitation Services; Unlimited.
Hospice Care	Covered after deductible	50% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	Covered after deductible	50% Coinsurance after deductible	Covered for authorized services; Up to 45 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	50% Coinsurance after deductible	Covered for approved equipment only.
Vision Hardware	Covered - Deductible does not apply	Not Covered	Coverage for one pair of eye glasses per benefit period. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents. No coverage for Adult Vision Hardware.;
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$45 Copay after deductible	50% Coinsurance after deductible	May be rendered at home; Rehabilitative Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Rehabilitative Speech Therapy up to 30 visits per benefit period. (Combined In-Network and Out-of-Network)
Habilitation Services	$45 Copay after deductible	50% Coinsurance after deductible	Physical and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. (Combined In and Out-of-Network). Limits and OON benefits do not apply for treatment of autism. See Outpatient Mental Health for ABA.;
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy.
Infertility Services	Covered after deductible	50% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	Not Covered	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$5 Copay 30 day supply, $10 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	$25 Copay 30 day supply, $50 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	20% Coinsurance ($200 max) 30 day supply at Specialty pharmacy only		
Non Preferred Specialty Drugs	50% Coinsurance ($500 max) 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 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.
- PPO plans are offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.