Alliance Health and Life Insurance Company PP001103 / XR001604

Coverage for: Individual + Family | Plan Type: PPO
PP001103 XR001604

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-999-4347 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-999-4347 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**IN-NETWORK** **$2,000** self only coverage / **$4,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. **OUT-OF-NETWORK** **$4,000** self only coverage / **$8,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. some Office Visits, Preventive services, some Pharmacy	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	**IN-NETWORK:** **Out-of-Pocket Limit:** **$2,500** self only coverage / **$5,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. **OUT-OF-NETWORK:** **Out-of-Pocket Limit:** **$5,000** self only coverage / **$10,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-888-999-4347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Specialist visit	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Other practitioner office visit	Telehealth Visit: 20% Coinsurance after deductible Chiropractic Visit: 20% Coinsurance after deductible	40% Coinsurance after deductible	Telehealth: Through our contracted telehealth services provider. Not covered Out-of-Network. Chiropractic: Manipulation of the spine for subluxation only; Up to 20 visits per benefit period (Combined In-Network and Out-of-Network).
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	Services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.hap.org	Preferred Generic drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	
	Preferred Brand drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	
	Non-preferred Brand drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	
	Preferred Specialty drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply.
	Non-preferred Specialty drugs	20% Coinsurance / prescription (retail) after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% Coinsurance after In-Network deductible	20% Coinsurance after In-Network deductible	
	Emergency medical transportation	20% Coinsurance after In-Network deductible	20% Coinsurance after In-Network deductible	Emergency transport only
	Urgent care	20% Coinsurance after In-Network deductible	20% Coinsurance after In-Network deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755. OON Benefits do not apply to ABA.
	Inpatient services	20% Coinsurance after deductible	40% Coinsurance after deductible	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	20% Coinsurance after deductible	40% Coinsurance after deductible	Prenatal covered under Preventive Services. Prenatal not covered Out-Of-Network
	Childbirth/delivery professional services	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Childbirth/delivery facility services	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	Does not include Rehabilitation Services; Up to 100 visits per benefit period (Combined In-Network and Out-of-Network).
	Rehabilitation services	20% 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	20% Coinsurance 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. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 100 days per benefit period (Combined In-Network and Out-of-Network).
	Durable medical equipment	20% Coinsurance after deductible	40% Coinsurance after deductible	Covered for approved equipment only
	Hospice services	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 210 days per benefit period (Combined In-Network and Out-of-Network).
If your child needs dental or eye care	Children's eye exam	20% Coinsurance after deductible	40% Coinsurance after deductible	One routine eye exam per benefit period at no cost share (In-Network only).
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery
• Dental Care (Adult)	• Hearing Aids	• Infertility Treatment
• Long-Term Care	• Non-Emergency Care Outside the U.S.	• Private Duty Nursing
• Routine Foot Care	• Vision Hardware	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Routine Eye Care (Adult)	• Voluntary Termination of Pregnancy

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: contact the plan at 1-888-999-4347 you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-888-999-4347; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O.Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,561**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work)*
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$2,522**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests (*x-ray)*
Durable medical equipment (*crutches*)
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$83
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,083**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English, call (800) 422-4641 (TTY: 711).

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。
TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ܙܘܼܗܵܪܵܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ\ܐܬܘܪܝܐ، ܬܫܡܫܝܬܐ ܕܗܝܪܐ ܠܫܢܝܐ ܒܠܫܢܐ ܡܢ ܕܠܐ ܦܠܚܐ، ܩܪܝ ܥܠ ܡܢܝܢܐ (800) 422-4641 ܐܘ ܥܠ TTY: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad.
Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)
Summary of Benefits
PP001103 / XR001604

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$2,000 Self Only; $4,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$4,000 Self Only; $8,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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	20%	40%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,500 Self Only; $5,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$5,000 Self Only; $10,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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	20% Coinsurance after deductible	40% Coinsurance after deductible	
Telehealth Visit	20% Coinsurance after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	20% Coinsurance after deductible	40% 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	20% Coinsurance after deductible	40% 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	20% Coinsurance after deductible	40% Coinsurance after deductible	
Allergy Injections	20% Coinsurance after deductible	40% Coinsurance after deductible	
Laboratory & Pathology	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	40% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	40% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	40% Coinsurance after deductible	
Dialysis	20% Coinsurance after deductible	40% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	20% Coinsurance after deductible	40% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	40% Coinsurance after deductible	
Ambulatory Surgical Center	20% Coinsurance after deductible	40% Coinsurance after deductible	
Professional Surgical and Related Services	20% Coinsurance after deductible	40% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	20% Coinsurance after In-Network Deductible		
Emergency Room Care	20% Coinsurance after In-Network Deductible		
Emergency Medical Transportation	20% Coinsurance after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	40% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	40% Coinsurance after deductible	
Bariatric Surgery and Related Services	Not Covered	Not Covered	

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Postnatal Office Visits	20% Coinsurance after deductible	40% 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	20% Coinsurance after deductible	40% Coinsurance after deductible	
Other Services			
Home Health Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Does not include Rehabilitation Services; Up to 100 visits per benefit period (Combined In and Out-of-Network).
Hospice Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 210 days per benefit period (Combined In and Out-of-Network).
Skilled Nursing Care	20% Coinsurance after deductible	40% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	40% Coinsurance after deductible	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	20% 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	20% Coinsurance after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	20% Coinsurance after deductible	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
Voluntary Termination of Pregnancy	See Outpatient Surgical Services	See Outpatient Surgical Services	During first trimester only. Limited to 1 within a 24 month period.
Temporomandibular Joint Disorder	Not Covered	Not Covered	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	20% Coinsurance after deductible		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% Coinsurance after deductible		
Preferred Brand Drugs	20% Coinsurance after deductible		
Non-Preferred Brand Drugs	20% Coinsurance after deductible		
Preferred Specialty Drugs	20% Coinsurance 30 day supply at Specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	20% Coinsurance 30 day supply at Specialty pharmacy only after deductible		

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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.