

**Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)**
Summary of Benefits
HAP PPO Silver 3500 HSA
PPO
PPQ00064 / XRQ00132

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	\$3,500 Self Only; \$7,000 Family Not to exceed \$6,650 from any one person	\$7,000 Self Only; \$14,000 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%	50%	Coinsurance applies towards the Annual Out-of-Pocket Maximum.
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	\$6,650 Self Only; \$13,300 Family Not to exceed \$6,650 from any one person	N/A	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates. 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	50% Coinsurance after deductible	
Telehealth Visit	Covered after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	20% Coinsurance after deductible	50% Coinsurance after deductible	
Audiology Office Visit	20% Coinsurance after deductible	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	20% Coinsurance after deductible	50% Coinsurance after deductible	One routine eye exam per benefit period at no cost share. Routine exam not covered Out-of-Network.
Chiropractic Services	20% Coinsurance after deductible	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	20% Coinsurance after deductible	50% Coinsurance after deductible	
Allergy Injections	20% Coinsurance after deductible	50% Coinsurance after deductible	
Laboratory & Pathology	20% Coinsurance after deductible	50% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	50% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	50% Coinsurance after deductible	
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	50% Coinsurance after deductible	
Dialysis	20% Coinsurance after deductible	50% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	50% Coinsurance after deductible	
Ambulatory Surgical Center	20% Coinsurance after deductible	50% Coinsurance after deductible	
Professional Surgical and Related Services	20% Coinsurance after deductible	50% 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	50% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	50% Coinsurance after deductible	
Bariatric Surgery and Related Services	20% Coinsurance 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	20% Coinsurance after deductible	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	20% Coinsurance after deductible	50% Coinsurance after deductible	OON Benefits do not apply to ABA.
Other Services			
Home Health Care	20% Coinsurance after deductible	50% Coinsurance after deductible	Does not include Rehabilitation Services; Unlimited.
Hospice Care	20% Coinsurance after deductible	50% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	20% Coinsurance 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	20% Coinsurance 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	20% Coinsurance 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	20% Coinsurance 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	20% Coinsurance 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	20% Coinsurance after deductible	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.
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 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.