

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



Alliance Health  
and Life Insurance  
Company

AS000098 / XR002358 / XW000713

Coverage for: Individual + Family | Plan Type: ASO HMO

AS000098 XR002358 XW000713

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 1-800-422-4641 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 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductibles</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Out-of-Pocket Limit:</b> \$6,600 individual/ \$13,200 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> 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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.hap.org">www.hap.org</a> or call 1-800-422-4641 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plans network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a> 's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	Written <a href="#">referrals</a> are not required for <a href="#">specialist</a> visits within the member's assigned <a href="#">network</a> for selected services. <a href="#">Referrals</a> or oral approvals are required in other instances. Further information on the <a href="#">referral</a> process can be found at <a href="http://www.hap.org">www.hap.org</a> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">Copay</a>	Not Covered	
	<a href="#">Specialist</a> visit	\$40 <a href="#">Copay</a>	Not Covered	
	Other practitioner office visit	Telehealth Visit: \$25 <a href="#">Copay</a> Chiropractic Visit: Not Covered	Not Covered	Telehealth: Through our contracted telehealth services provider.
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not Covered	Coverage information available at <a href="http://www.hap.org">www.hap.org</a> . You may have to pay for services that aren't <a href="#">preventive services</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive services</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	Some services require <a href="#">preauthorization</a>
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require <a href="#">preauthorization</a>

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)	
<b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hap.org">www.hap.org</a>	Preferred Generic drugs	\$20 <a href="#">Copay</a> / prescription (retail)	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 <a href="#">Copay</a> / prescription (retail)	Not Covered	
	Preferred Brand drugs	\$40 <a href="#">Copay</a> / prescription (retail)	Not Covered	
	Non-preferred Brand drugs	\$60 <a href="#">Copay</a> / prescription (retail)	Not Covered	
	Preferred <a href="#">Specialty drugs</a>	\$60 <a href="#">Copay</a> / prescription (retail)	Not Covered	All <a href="#">specialty drugs</a> are limited to a 30-day supply at a specialty pharmacy only. Certain <a href="#">specialty drugs</a> may be approved for 60 or 90 days. In this case, if a <a href="#">Copay</a> 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 <a href="#">Specialty drugs</a>	\$60 <a href="#">Copay</a> / prescription (retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center(ASC))	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> .
	Physician/surgeon fees	No Charge	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">Copay</a>	\$200 <a href="#">Copay</a>	<a href="#">Copay</a> will be waived if admitted
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Emergency transport only
	<a href="#">Urgent care</a>	\$50 <a href="#">Copay</a>	\$50 <a href="#">Copay</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> .
	Physician/surgeon fees	No Charge	Not Covered	

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">Copay</a>	Not Covered	Some services require <a href="#">preauthorization</a> . Services can be accessed by calling 1-800-444-5755.
	Inpatient services	No Charge	Not Covered	Services require <a href="#">preauthorization</a> . Services can be accessed by calling 1-800-444-5755.
<b>If you are pregnant</b>	Office visits	\$40 <a href="#">Copay</a>	Not Covered	Prenatal covered under <a href="#">Preventive Services</a> .
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	Some services require <a href="#">preauthorization</a>
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	Not Covered	Does not include <a href="#">Rehabilitation Services</a> ; Unlimited.
	<a href="#">Rehabilitation services</a>	No Charge	Not Covered	May be rendered at home; Up to 60 combined visits per benefit period.
	<a href="#">Habilitation services</a>	No Charge	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 <a href="#">cost sharing</a> amount.
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Covered for authorized services; Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Covered for approved equipment only
	<a href="#">Hospice services</a>	No Charge	Not Covered	Up to 210 days per lifetime.

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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40 <a href="#">Copay</a>	Not Covered	One exam per benefit period. For non-routine visits see <a href="#">Specialist Office Visit</a> .
	Children's glasses	No Charge	Not Covered	Glasses or contacts for adults and children are covered once during each 12-month consecutive period. Detailed information regarding coverage of lenses and Collection frames can be found in your policy or plan documents.
	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          | • Chiropractic Care | • Cosmetic Surgery                    |
| • Dental Care (Adult)  | • Long-Term Care    | • Non-Emergency Care Outside the U.S. |
| • Private Duty Nursing | • Routine Foot Care | • Voluntary Termination of Pregnancy  |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                            |                        |                         |
|----------------------------|------------------------|-------------------------|
| • Bariatric Surgery        | • Hearing Aids         | • Infertility Treatment |
| • Routine Eye Care (Adult) | • Weight Loss Programs |                         |

**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 1-800-422-4641 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](http://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](http://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 1-800-422-4641; 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](mailto: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.*

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility)	\$0	■ Hospital (facility)	\$0	■ Hospital (facility)	\$0
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%

**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*)

**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*)

**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		\$12,700	Total Example Cost		\$5,600	Total Example Cost		\$2,800
<b>In this example, Peg would pay:</b>			<b>In this example, Joe would pay:</b>			<b>In this example, Mia would pay:</b>		
<i>Cost Sharing</i>			<i>Cost Sharing</i>			<i>Cost Sharing</i>		
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0	Deductibles	\$0	
Copayments	\$10	Copayments	\$944	Copayments	\$325	Copayments	\$325	
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0	
<i>What isn't covered</i>			<i>What isn't covered</i>			<i>What isn't covered</i>		
Limits or exclusions	\$61	Limits or exclusions	\$22	Limits or exclusions	\$0	Limits or exclusions	\$0	
<b>The total Peg would pay is</b>	<b>\$71</b>	<b>The total Joe would pay is</b>	<b>\$966</b>	<b>The total Mia would pay is</b>	<b>\$325</b>			

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

