Alliance Health and Life Insurance Company (Alliance)
Exclusive Provider Organization (EPO)

Summary of Benefits

HAP EPO 2000-0 HSA A / RX 2H / WRAP **EPO**

PPS00085

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.	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$3,000 Self Only; $6,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after deductible	N/A	
Telehealth Visit	Covered after deductible	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	Covered after deductible	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	Covered after deductible	N/A	Manipulation of the spine for subluxation only. Up to 20 visits per benefit period.
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Outpatient Medical Drugs	Covered after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	Covered after deductible		
Emergency Room Care	Covered after deductible		
Emergency Medical Transportation	Covered after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered after deductible	N/A	One procedure per lifetime

Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered after deductible	N/A	
Other Services			
Home Health Care	Covered after deductible	N/A	Does not include Rehabilitation Services. Up to 100 visits per benefit period.
Hospice Care	Covered after deductible	N/A	Unlimited.
Skilled Nursing Care	Covered after deductible	N/A	Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	N/A	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids after deductible $689 Copay per Hearing Aid for Basic Technology Hearing Aids after deductible $989 Copay per Hearing Aid for Prime Technology Hearing Aids after deductible $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids after deductible $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids after deductible	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered - Deductible does not apply	N/A	Covered once each 12 month period thru HAP's Contracted Providers. $80 benefit maximum for Frames/Lens or Contact Lens. Details can be found in your policy or plan documents.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered after deductible	N/A	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	N/A	Limited to vasectomy.
Infertility Services	Covered after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered after deductible	N/A	One attempt per lifetime
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$7 Copay 30 day supply, $14 Copay 90 day supply 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 Copay 30 day supply, $40 Copay 90 day supply after deductible		
Preferred Brand Drugs	$30 Copay 30 day supply, $60 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply 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		

- In case of conflict between this summary and your EPO Group Health Insurance Policy and Riders, the terms and conditions of the EPO Group Health Policy and Riders will govern.
- 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.
- Students away at school are covered for acute illness and injury related services according to Alliance criteria.
- EPO plans are offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.
-For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.