

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY

Exclusive Provider Organization (EPO) plan

Qualified High Deductible Health Plan

GROUP NUMBER:	10004780	GROUP NAME:	CLARKSTON COMMUNITY SCHOOLS AHL
PRODUCT ID:	PPS02610 / XRS03529	PRODUCT TYPE:	EPO
COVERAGE DATES:	07/01/2026 - 06/30/2027	BENEFIT PERIOD:	Fiscal Year
PLAN NAME:	HAP EPO Custom 6242 / Rx EPO Custom 6242		

This Schedule of Benefits provides you with information regarding the Cost-Sharing and any Maximum Benefits related to the Covered Services provided under the Policy. Please read the entire Policy and the Schedule of Benefits carefully.

This Schedule of Benefits is intended to be part of a Qualified High Deductible Health Plan (QHDHP) for an eligible individual to meet the requirements of a Health Savings Account (HSA). If any part of the Policy, this Schedule of Benefits, or the QHDHP design does not meet the requirements of an HSA, We will amend it accordingly.

All Covered Services provided in the Policy or in a separate Rider are subject to the Deductible unless otherwise indicated in this Schedule of Benefits. This is true for both Self-Only Coverage and Family Coverage.

Qualified High Deductible Health Plan ("QHDHP") means a plan that satisfies certain requirements with respect to minimum annual Deductibles and maximum annual Out-of-Pocket Limits for Self-Only Coverage and Family Coverage.

Self-Only Coverage means the Policy provides coverage for only one person.

Family Coverage means the Policy provides coverage for more than one person.

Self Only Coverage

At the beginning of each Benefit Period You must pay for all Covered Services until You meet the following Annual Deductible for Self-Only Coverage. Once You meet this Deductible, You pay any applicable Copays and/or Coinsurance for Covered Services and We pay the rest. This continues until Your costs reach the following Annual Out-of-Pocket Limit for Self-Only Coverage. Once You meet this Out-of-Pocket Limit, We pay 100% of the Allowable Amount for Covered Services for the rest of the Benefit Period.

PLAN ATTRIBUTES	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Annual Deductible	\$1,700	N/A
Coinsurance	None	N/A
Annual Out-of-Pocket Limit	\$2,350	N/A

Family Coverage (Aggregate/Aggregate)

At the beginning of each Benefit Period everyone covered under the Policy must pay for all Covered Services until the family collectively meets the following Annual Deductible. Once this Deductible is met, everyone pays any applicable Copays and/or Coinsurance for Covered Services and We pay the rest. This continues until everyone's costs collectively reach the following Annual Out-of-Pocket Limit. Once this Out-of-Pocket Limit is met, We pay 100% of the Allowable Amount for Covered Services for everyone covered under the Policy, for the rest of the Benefit Period.

PLAN ATTRIBUTES	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Annual Deductible	\$3,400	N/A
Coinsurance	None	N/A
Annual Out-of-Pocket Limit	\$4,700	N/A

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HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Preventive Services		
Routine Well Visits	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 Physician Office Visits to treat Illness or Injury • Family Practice • General Practice • Internal Medicine • Pediatrician Includes Physician home visits	Covered after Deductible	Not Covered
HAP Telehealth Through our Designated Telehealth Partner.	Covered after Deductible	Not Covered
Specialist Office Visit Includes Physician home visits	Covered after Deductible	Not Covered
Routine Audiology Exam One exam per Benefit Period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Eye Exam One exam per Benefit Period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Chiropractic Services Up to 20 visits per benefit period.	Covered after Deductible	Not Covered
Allergy Treatment	Covered after Deductible	Not Covered
Allergy Injections	Covered after Deductible	Not Covered
Diagnostic Laboratory & Pathology	Covered after Deductible	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	Covered after Deductible	Not Covered
Radiology (X-ray)	Covered after Deductible	Not Covered
Radiation Therapy & Chemotherapy	Covered after Deductible	Not Covered
Dialysis	Covered after Deductible	Not Covered
Genetic Testing	Covered after Deductible	Not Covered
Outpatient Medical Drugs	Covered after Deductible	Not Covered

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HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Hospital and Ambulatory Surgical Center Services		
Physician & Other Professional Services	Covered after Deductible	Not Covered
Diagnostic Laboratory & Pathology	Covered after Deductible	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	Covered after Deductible	Not Covered
Radiology (X-ray)	Covered after Deductible	Not Covered
Outpatient Hospital Surgical Facility (OP Hosp)	Covered after Deductible	Not Covered
Ambulatory Surgical Center (ASC)	Covered after Deductible	Not Covered
Radiation Therapy & Chemotherapy	Covered after Deductible	Not Covered
Dialysis	Covered after Deductible	Not Covered
Emergency / Urgent Care		
Urgent Care	Covered after Deductible	
Emergency Room Services	Covered after Deductible	
Emergency Medical Transportation Emergency Transport Only	Covered after Deductible	
Inpatient Hospital Services		
Facility Fee	Covered after Deductible	Not Covered
Physician Services, Surgery, Therapy & Other Hospital Services	Covered after Deductible	Not Covered
Diagnostic & Laboratory Services • X-rays • Lab Tests • MRI's • CT Scans • PET Scans • Other imaging services	Covered after Deductible	Not Covered
Bariatric Surgery & Related Services	Not Covered	Not Covered
Maternity Services		
Routine Prenatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Postnatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Inpatient Hospital, Labor, Delivery & Newborn Care	Covered after Deductible	Not Covered
Transplant Services		
Organ Transplant Surgery & Related Services	Covered after Deductible	Not Covered

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HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Mental Health & Substance Use Disorder Services		
Inpatient Services	Covered after Deductible	Not Covered
Outpatient Services	Covered after Deductible	Not Covered
Autism Spectrum Disorder Services		
Physical, Occupational and Speech Therapy for Treatment of Autism Spectrum Disorder	Covered after Deductible	Not Covered
Applied Behavioral Analysis for Treatment of Autism Spectrum Disorder	Covered after Deductible	Not Covered
Other Services		
Home Health Care Does not include Rehabilitation Services. Up to 100 visits per benefit period.	Covered after Deductible	Not Covered
Hospice Care Up to 210 days per lifetime	Covered after Deductible	Not Covered
Skilled Nursing Facility Up to 100 days per benefit period.	Covered after Deductible	Not Covered
Durable Medical Equipment (DME); Prosthetics & Orthotics Covered for approved equipment only.	Covered after Deductible	Not Covered
Physical, Occupational & Speech Therapy May be rendered at home. Up to 60 combined visits per Benefit Period.	Covered after Deductible	Not Covered
Temporomandibular Joint Disorder	Covered after Deductible	Not Covered

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Additional Health Care Services		
Hearing Aid Hardware Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.	\$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	Not Covered
Voluntary Sterilizations Limited to vasectomy.	Covered after Deductible	Not Covered
Fertility Preservation	Not Covered	Not Covered
Infertility Services Services for diagnosis, counseling & treatment of bodily disorders causing infertility.	Covered after Deductible	Not Covered
Assisted Reproductive Technologies One attempt per lifetime	Covered after Deductible	Not Covered
Voluntary Termination of Pregnancy During first trimester only. Limited to 1 within a 24 month period.	Covered after Deductible	Not Covered

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OUTPATIENT PRESCRIPTION DRUGS (Affiliated Pharmacy Providers only) Cost-Share applies to each prescription or refill		
Drug Type	Retail Pharmacy	Mail Order & 90-Day Retail Pharmacy*
Tier 1	\$5 Copay after Deductible	\$10 Copay after Deductible
Tier 2	\$5 Copay after Deductible	\$10 Copay after Deductible
Tier 3	\$25 Copay after Deductible	\$50 Copay after Deductible
Tier 4	\$40 Copay after Deductible	\$80 Copay after Deductible
Tier 5	\$40 Copay after Deductible	Not Applicable**
Tier 6	\$40 Copay after Deductible	Not Applicable**
Maximum Supply per prescription or refill	Up to a 30-day supply and/or restricted quantity limit.	Up to a 90-day supply and/or restricted quantity limit.

*** A 90-day supply of non-Maintenance Drugs must be filled at the designated mail order pharmacy.**

** Tier 5 & Tier 6 (specialty drugs) are limited to a 30-day supply per fill. In certain situations, greater than a 30-day supply may be approved. If a Copay or Maximum is shown above, You will pay two times that amount for a supply of up to 60 days, and three times that amount for a supply of up to 90 days.

****For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

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Schedule of Benefits Definitions

Coinsurance means the percentage of the Allowable Amount for certain Covered Services paid by You after the Deductible has been met. Coinsurance may vary depending upon the Covered Services received. The Coinsurance percentages are shown in this Schedule of Benefits.

Copayment or Copay means a set dollar amount You must pay for certain Covered Services each time You obtain the Covered Service. Applicable Copayment amounts are shown in this Schedule of Benefits. Not all Covered Services have a Copayment. Copayments do not count toward the Deductible or Coinsurance. Copayments do count toward the Out-of-Pocket Limit.

Deductible means the set dollar amount You must pay for Covered Services before payment of benefits under this Policy begins. There are separate Deductibles for Self-Only Coverage and Family Coverage. All Deductibles start over at the beginning of each Benefit Period.

Out-of-Pocket Limit is the most You will pay for the combined total of all Copayments, Coinsurance and Deductibles for Covered Services in a Benefit Period. There are separate Out-of-Pocket Limits for Self-Only Coverage and Family Coverage. All Out-of-Pocket Limits start over at the beginning of each Benefit Period.

Except as otherwise specified in this Schedule of Benefits, the following amounts paid by You do not count toward the Out-of-Pocket-Limit:

- a. Charges that exceed the Allowable Amounts for Covered Services;
- b. Charges that exceed any Maximum Benefits described in the Policy, any attached Rider or in this Schedule of Benefits;
- c. Charges for services that are not Prior Authorized, if Prior Authorization is required, as described in the Policy;
- d. Charges for services that are not Covered Services in the Policy or any attached Rider; and
- e. Premiums.