Health Alliance Plan of Michigan

Health Maintenance Organization (HMO) Plan

Summary of Benefits for

STATE OF MICHIGAN ACTIVES - COVERAGE IS EXCLUDED FOR MSPTA (T01)

AA002114

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Plan Year (Fiscal)	
Annual Deductible	$125 Individual ; $250 Family	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	$2,000 Individual ; $4,000 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, and penalties. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	Covered up to 24 months
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$20 Copay - Deductible does not apply	Home visit by physician is also covered when medically necessary
Specialty Physician Office Visit	$20 Copay - Deductible does not apply	Home visit by physician is also covered when medically necessary
Gynecology Office Visit	$20 Copay - Deductible does not apply	
Audiology Office Visit	$20 Copay - Deductible does not apply	
Eye Exam Office Visit	$20 Copay - Deductible does not apply	
Allergy Treatment and Injections	Deductible does not apply	
Laboratory and Pathology Services	Deductible does not apply	
Radiology Services	Covered after Deductible	
Dialysis	Covered after Deductible	
Chemotherapy	Covered after Deductible	
Radiation Therapy	Covered after Deductible	
Outpatient Surgery	Covered after Deductible	
Chiropractic Office Visit and Related Services	$20 Copay - after deductible	Up to 24 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$200 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$20 Copay - Deductible does not apply	
Emergency Ambulance Services	Covered after Deductible	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after Deductible	
Bariatric Surgery & Related Services	$1,000 Copay after Deductible	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered - Deductible does not apply	
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	
Postnatal Office Visits	$20 Copay - Deductible does not apply	
Labor, Delivery and Newborn Care	Covered after Deductible	
Mental /Behavioral Health:		
Inpatient Services	Covered after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Substance Use Disorder:		
Inpatient Services	Covered after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Other Services:		
Home Health Care	$20 Copay - Deductible does not apply	Unlimited - See PT/OT/ST Coverage
Hospice Care	Covered after Deductible	Up to 210 days per lifetime
Private Duty Nursing	Deductible does not apply	Covered for authorized services
Skilled Nursing Care	Covered after Deductible	Covered for authorized services - Up to 120 days (per confinement)
Durable Medical Equipment; Prosthetic & Orthotics	Deductible does not apply	Coverage provided for approved equipment based on HAP's guidelines, With Wigs
Hearing Aid Hardware	Covered after Deductible	Covered for authorized equipment
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Deductible does not apply	Up to 100 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100% after Deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Services**
Voluntary Termination of Pregnancy	Covered after Deductible	
Infertility Services	Covered after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered after Deductible	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	$10 / $30 / $60 Copay - Deductible does not apply	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Benefit Riders: K50,K51,K49,K61,K52,540,599,588,573,317,127,126,118,086,K53,013,902

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.