Health Alliance Plan
by Henry Ford Health

Health Alliance Plan of Michigan
Employer Group Waiver Plan HMO
Summary of Benefits
MA000168 / XS000118

HMO

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$500 Individual	N/A	Copayments and Coinsurance do not apply toward the Deductible. Amounts paid toward the Deductible count toward the Annual Out of Pocket Limit. The Deductible does not apply to all covered services. See the Evidence of Coverage (EOC) for details
Co-insurance	10%	N/A	Coinsurance does not apply to all covered services. Refer to your Evidence of Coverage (EOC) for specific Coinsurance amounts and coverage details
Annual Co-insurance Maximum	$2,200 Individual	N/A	
Maximum-Out-of-Pocket Limit	$2,700 Individual	N/A	Premiums, Balance Billed charges, Part D drug costs, and non covered services do not count toward the Out of Pocket maximum. All other Cost Sharing applies unless stated otherwise.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
HAP Telehealth	$20 Copay - Deductible does not apply	N/A	Through our Designated Telehealth Partner
Specialist Office Visit	$40 Copay - Deductible does not apply	N/A	
Routine Hearing Exam	Covered - Deductible does not apply	N/A	For non-routine visits see Specialist Office Visit.
Routine Eye Exam	$40 Copay - Deductible does not apply	N/A	For non-routine visits see Specialist Office Visit.
Chiropractic Services	$20 Copay - Deductible does not apply	N/A	See Evidence of Coverage (EOC) for benefits relating to chiropractic services. Unlimited.
Allergy Treatment	10% Coinsurance after Deductible	N/A	
Allergy Injections	10% Coinsurance after Deductible	N/A	
Laboratory & Pathology	10% Coinsurance after Deductible	N/A	Some services require Prior Authorization.
Imaging MRI, CT & PET Scans	10% Coinsurance after Deductible	N/A	Some services require Prior Authorization.
Radiology (X-ray)	10% Coinsurance after Deductible	N/A	Some services require Prior Authorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after Deductible	N/A	
Dialysis	10% Coinsurance after Deductible	N/A	
Outpatient Hospital & Ambulatory Surgical Center Services			
Outpatient Hospital Surgical Facility	10% Coinsurance after Deductible	N/A	
Ambulatory Surgical Center	10% Coinsurance after Deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$40 Copay - Deductible does not apply		
Emergency Room Care	$65 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	10% Coinsurance after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after Deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after Deductible	N/A	
Bariatric Surgery and Related Services	10% Coinsurance after Deductible	N/A	One procedure per lifetime

Mental Health & Substance Use Disorder Services			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	10% Coinsurance after Deductible	N/A	Unlimited.
Hospice Care	Covered - Deductible does not apply	N/A	You must get care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare.
Skilled Nursing Facility Services	Covered - Deductible does not apply	N/A	1-20 days. Services require Prior Authorization.
Skilled Nursing Facility Services Supp	10% Coinsurance after Deductible	N/A	After day 20 and Up to 730 days per Benefit Period.
Durable Medical Equipment; Prosthetics & Orthotics	10% Coinsurance after Deductible	N/A	Coverage provided for approved equipment based on Medicare guidelines.
Hearing Aid Hardware	Value technology $0 Copay per hearing aid Basic technology $175 Copay per hearing aid Prime technology $475 Copay per hearing aid Advanced technology $1,075 Copay per hearing aid Premium technology $1,575 Copay per hearing aid Deductible does not apply to any of these options	N/A	Through Health Alliance Plan's Contracted Providers only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit. See Evidence of Coverage (EOC) for full benefit details.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after Deductible	N/A	Medicare guidelines and authorization rules apply.
Visitor Traveler	Covered - Deductible does not apply	N/A	In-Network coverage with a Medicare-contracted provider when traveling to Florida, Arizona, Texas and out of area Michigan for up to 12 months. See EOC for full benefit details.
Fitness	Covered - Deductible does not apply	N/A	See Evidence of Coverage (EOC) for full benefit details.
Temporomandibular Joint Disorder Treatment	10% Coinsurance after Deductible	N/A	Covered when medically necessary.
Outpatient Prescription Drugs (Affiliated Pharmacy Providers only)			
Tier 1	$3 Copay 30 - day supply, $6 Copay 90 - day supply		Retail/Mail Order: 30-day supply for Part D drugs for 1 copay. 31-90-day supply of Part D drugs available for 2 times the 30-day copay. Tier 5 drugs are only available at 30-day supply. Tier 1 drugs are available at a 100-day supply at retail and mail order.
Tier 2	$15 Copay 30 - day supply, $30 Copay 90 - day supply		
Tier 3	$45 Copay 30 - day supply, $90 Copay 90 - day supply after Deductible		
Tier 4	30% Coinsurance after Deductible		
Tier 5	30% Coinsurance 30 - day supply at Specialty pharmacy after Deductible		

Important Plan Information

- **If there is a conflict between this summary and your Evidence of Coverage (EOC), the terms and conditions of the EOC will govern.**
- **Some services require prior authorization.**
  Failure to obtain required prior authorization may result in a reduction or denial of benefits.
- **For outpatient mental health services provided through HAP Telehealth,** you will pay the lower of the Outpatient Mental Health Disorder cost share or the HAP Telehealth cost share.