Health Alliance Plan of Michigan
Health Maintenance Organization (HMO-POS) Plan
Summary of Benefits

HAP HMO POS Custom 2412 / Rx HMO POS Custom 2412
Michigan Public Schools Employees Retirement Systems
Non-Medicare

HMO-POS

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$600 Individual; $1,200 Family	$1,500 Individual; $3,000 Family	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	10%	30%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$4,000 Individual; $8,000 Family	$8,000 Individual; $16,000 Family	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. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	30% Coinsurance after Deductible	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	30% Coinsurance after Deductible	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	30% Coinsurance after Deductible	
Immunizations	Covered - Deductible does not apply	30% Coinsurance after Deductible	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	
Telehealth Visit	Covered – Deductible does not apply		Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay - Deductible does not apply	30% Coinsurance after Deductible	
Routine Audiology Exam	Covered - Deductible does not apply		One exam per benefit period. Through our contracted provider only. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply		One exam per benefit period. Through our contracted provider only. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	Up to 30 visits per benefit period. (Combined In and Out-of-Network)
Allergy Injections	Covered after Deductible	30% Coinsurance after Deductible	
Laboratory & Pathology	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	$150 Copay per test – Deductible does not apply	30% Coinsurance after Deductible	Services require preauthorization.
Radiology (X-ray)	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Dialysis	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Outpatient Medical Drugs	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Outpatient Surgical Services			
Outpatient Surgery	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Ambulatory Surgical Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Professional Surgical and Related Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Emergency/Urgent Care			
Urgent Care	$60 Copay - Deductible does not apply		
Emergency Room Care	$150 Copay - Deductible does not apply		Copay will be waived if admitted.
Emergency Medical Transportation	$100 Copay – Deductible does not apply		Emergency transport only via land or air.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Bariatric Surgery and Related Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	One procedure per lifetime (Combined In and Out-of-Network)
Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	30% Coinsurance after Deductible	Covered under Preventive Services
Routine Postnatal Office Visits	Covered - Deductible does not apply	30% Coinsurance after Deductible	Covered under Preventive Services
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	
Other Services			
Home Health Care	Covered after Deductible	30% Coinsurance after Deductible	Does not include Rehabilitation Services.Up to 100 visits per benefit period. (Combined In and Out-of-Network)
Hospice Care	Covered – Deductible does not apply	30% Coinsurance after Deductible	Unlimited.
Skilled Nursing Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Covered for authorized services. Up to 100 days per benefit period, renewable after 60 days of non-confinement. (Combined In and Out-of-Network)
Durable Medical Equipment; Prosthetics & Orthotics	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Covered for approved equipment only.
Hearing Aid Hardware	$499 copay per hearing aid for Advanced Aids $799 copay per hearing aid for Premium Aids		Through a NationsHearing Provider only. Limited to 2 Hearing Aids per benefit period. Copays do not count towards the Out-of-Pocket Limit. Visit HAP.NationsBenefits.com/Hearing for details.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	May be rendered at home. Up to 30 visits for PT/OT and 30 visits for ST per benefit period. (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Applied Behavioral Analysis	$25 Copay - Deductible does not apply	30% Coinsurance after Deductible	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy Covered in full if procedure performed in physician office visit (In-Network only).
Infertility Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
	PRESCRIPTION DRUG COINSURANCE MAX $1,750 Individual / $3,500 Family (This does accrue towards the annual In-Nework Out-of-Pocket Limit)		For details on your plan accruals, Log in at www.Hap.org, then select: My Benefits > My Prescription Coverage > Benefit Overview
Tier 1	$10 Copay 30 day supply, $20 Copay 90 day supply		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.
Tier 2	$10 Copay 30 day supply, $20 Copay 90 day supply		
Tier 3	$50 Copay 30 day supply, $100 Copay 90 day supply		
Tier 4	$80 Copay 30 day supply, $160 Copay 90 day supply		
Tier 5	20% Coinsurance ($150 max) 30 day supply at specialty pharmacy only		
Tier 6	20% Coinsurance ($150 max) 30 day supply at specialty pharmacy only		

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- In case of conflict between this summary and your HMO-POS Subscriber Contract and Riders, the terms and conditions of the HMO-POS Subscriber Contract and Riders will govern.
- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours after any emergency hospital admission. Failure to notify HAP 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 HAP criteria.
- 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.