Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

GROUP NUMBER:	**10000727**	**GROUP NAME:**	**COUNTY OF OAKLAND HMO**
PRODUCT ID:	**AA001592 / XR002406**	**PRODUCT TYPE:**	**HMO**
COVERAGE DATES:	**01/01/2021 - 12/31/2021**	**BENEFIT PERIOD:**	**CALENDAR YEAR**
PLAN NAME:	**AA001592 / XR002406**		

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

PLAN ATTRIBUTES	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Annual Deductible • **Individual** • **Family**	 None None	 N/A N/A
Coinsurance	None	N/A
Annual Coinsurance Maximum • **Individual** • **Family**	 None None	 N/A N/A
Annual Out-of-Pocket Limit • **Individual** • **Family**	 $6,600 $13,200	 N/A N/A

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Preventive Services		
Office Visit / Physical Exam / Well Baby Exam	Covered	Not Covered
Related Laboratory and Radiology Services	Covered	Not Covered
Pap smear, mammogram, tubal ligation	Covered	Not Covered
Immunizations	Covered	Not Covered

Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient & Physician Services		
Primary Care Physician Office Visits to treat Illness or Injury • Family Practice • General Practice • Internal Medicine • Pediatrician Includes Physician home visits	$20 Copay per visit	Not Covered
Telehealth Visits Through Our Contracted Telehealth Services Provider Only	$20 Copay per visit	Not Covered
Specialist Office Visit Includes Physician home visits	$20 Copay per visit	Not Covered
Routine Audiology Exam One exam per Benefit Period. For non-routine visits see Specialist Office Visit.	Covered	Not Covered
Routine Eye Exam One exam per Benefit Period. For non-routine visits see Specialist Office Visit.	Covered	Not Covered
Chiropractic Services	Not Covered	Not Covered
Allergy Treatment	Covered	Not Covered
Allergy Injections	Covered	Not Covered
Diagnostic Laboratory & Pathology	Covered	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	Covered	Not Covered
Radiology (X-ray)	Covered	Not Covered
Radiation Therapy & Chemotherapy	Covered	Not Covered
Dialysis	Covered	Not Covered
Outpatient Medical Drugs Drugs that are injected or infused by a healthcare professional	Covered	Not Covered
Outpatient Hospital and Ambulatory Surgical Center Services		
Physician & Other Professional Services	Covered	Not Covered
Diagnostic Laboratory & Pathology	Covered	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	Covered	Not Covered
Radiology (X-ray)	Covered	Not Covered
Outpatient Hospital Surgical Facility (OP Hosp)	Covered	Not Covered
Ambulatory Surgical Center (ASC)	Covered	Not Covered
Radiation Therapy & Chemotherapy	Covered	Not Covered
Dialysis	Covered	Not Covered

Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Emergency / Urgent Care		
Urgent Care	$20 Copay per visit	
Emergency Room Services Copay will be waived if admitted	$100 Copay per visit	
Emergency Medical Transportation Emergency Transport Only	Covered	
Inpatient Hospital Services		
Facility Fee	Covered	Not Covered
Physician Services, Surgery, Therapy & Other Hospital Services	Covered	Not Covered
Diagnostic & Laboratory Services • X-rays • Lab Tests • MRI's • CT Scans • PET Scans • Other imaging services	Covered	Not Covered
Bariatric Surgery & Related Services One procedure per lifetime	$1,000 Copay per admission	Not Covered
Maternity Services		
Prenatal Office Visits Covered under Preventive Services	Covered	Not Covered
Postnatal Office Visits	$20 Copay per visit	Not Covered
Inpatient Hospital, Labor, Delivery & Newborn Care	Covered	Not Covered
Transplant Services		
Organ Transplant Surgery & Related Services	Covered	Not Covered
Mental Health & Substance Use Disorder		
Inpatient Services	Covered	Not Covered
Outpatient Services	$20 Copay per visit	Not Covered
Habilitation Services / Autism Spectrum Disorder Services - Coverage is limited to Subscribers & Dependents who are under age 19 only		
Physical, Occupational and Speech Therapy	Covered	Not Covered
Applied Behavioral Analysis (ABA)	$20 Copay per visit	Not Covered

Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Other Services		
Home Health Care Does not include Rehabilitation Services Unlimited.	Covered	Not Covered
Hospice Care Up to 210 days per lifetime.	Covered	Not Covered
Skilled Nursing Facility Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.	Covered	Not Covered
Durable Medical Equipment (DME); Prosthetics & Orthotics Covered for approved equipment only.	Covered	Not Covered
Physical, Occupational & Speech Therapy May be rendered at home. Up to 60 combined visits per benefit period.	Covered	Not Covered
Temporomandibular Joint Disorder Coverage for non-invasive treatments only.	Covered	Not Covered
Orthognathic Surgery	Covered	Not Covered
Reproductive Care & Family Planning Services		
Genetic Testing & Counseling	Covered	Not Covered
Voluntary Sterilizations Limited to vasectomy	Covered	Not Covered
Infertility Services Services for diagnosis, counseling & treatment of bodily disorders causing infertility.	Covered	Not Covered
Additional Health Care Services		
Assisted Reproductive Technologies One attempt per lifetime	Covered	Not Covered

Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

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 – Preferred Generic Drugs	$5 Copay	$5 Copay
Tier 1A – Non-Preferred Generic Drugs	$5 Copay	$5 Copay
Tier 2 – Preferred Brand Drugs	$20 Copay	$20 Copay
Tier 3 – Non-Preferred Brand Drugs	$40 Copay	$40 Copay
Tier 4 – Preferred Specialty Drugs	$40 Copay	Not Applicable**
Tier 4A – Non-Preferred Specialty Drugs	$40 Copay	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 4 & Tier 4A (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.

Schedule of Benefits

HEALTH ALLIANCE PLAN of MICHIGAN
Health Maintenance Organization (HMO) Plan

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.

Coinsurance Maximum means the maximum Coinsurance dollar amount paid by You for Covered Services during a Benefit Period. The Coinsurance Maximum does not include Copayments or the Deductible. If applicable, the Coinsurance Maximum is shown in this Schedule of Benefits.

Copayment or Copay means the 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, Coinsurance or Coinsurance Maximum. Copayments do count toward the Out-of-Pocket Limit.

Deductible means the set dollar amount You must pay for certain Covered Services before payment of benefits under this Contract begins. The Deductible applies to each Subscriber and Dependent and must be met each Benefit Period. Copayments are not applied to the Deductible. The Deductibles are shown in this Schedule of Benefits.

a. **Individual Deductible**
This is the Deductible amount that You pay each Benefit Period for certain Covered Services. The Allowable Amounts for these Covered Services are applied toward the Deductible for the Subscriber and each Dependent individually. Once Your Individual Deductible is met, benefits are payable for You only during that same Benefit Period.

b. **Family Deductible**
This is the Deductible amount that the Subscriber and all Dependents must collectively pay each Benefit Period for certain Covered Services. The Allowable Amounts for Covered Services that are applied toward each Individual Deductible are also applied toward the Family Deductible until the Family Deductible is met. Once the Family Deductible is met, benefits are payable for the Subscriber and all Dependents during that same Benefit Period.

Out-of-Pocket Limit is the most You will pay for the combined total of all Copays, Coinsurance and Deductibles for Covered Services in a Benefit Period. The Out-of-Pocket Limits are shown in this Schedule of Benefits.

a. Individual Out-of-Pocket Limit
This is the most You will pay for Covered Services each Benefit Period. The Cost-Sharing amounts paid are applied toward the Out-of-Pocket Limit for the Subscriber and each Dependent individually. Once Your Individual Out-of-Pocket Limit is met, We will pay Covered Services for You only at 100% of the Allowable Amount, for the rest of the Benefit Period.

b. Family Out-of-Pocket Limit
This is the most the Subscriber and all Dependents will pay collectively for Covered Services each Benefit Period. The Cost-Sharing amounts that are applied toward each Individual Out-of-Pocket Limit are also applied to the Family Out-of-Pocket Limit until the Family Out-of-Pocket Limit is met. Once the Family Out-of-Pocket Limit is met, We will pay Covered Services for the Subscriber and all Dependents at 100% of the Allowable Amount, for the rest of the 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 this Contract, any attached Rider or on the Schedule;
c. Charges for services that are not Covered Services in the Contract or any attached Rider; and
d. Premiums.