Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for
Detroit Public Schools

HENRY FORD PREFERRED NETWORK
ENHANCED
CORE
PLAN

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:	HENRY FORD PREFERRED NETWORK	
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 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	
Well Baby Office Visit	Covered	Covered up to 24 months
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$20 Copay	
Specialty Physician Office Visit	$20 Copay	
Gynecology Office Visit	$20 Copay	
Audiology Office Visit	$20 Copay	
Eye Exam Office Visit	$20 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	$100 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$50 Copay	
Emergency Ambulance Services	Covered	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	
Bariatric Surgery & Related Services	$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered	
Subsequent Prenatal Office Visits	Covered	
Postnatal Office Visits	$20 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental Health:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Chemical Dependency:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Other Services:		
Home Health Care	Covered	UNLIMITED
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Covered	
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	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	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	$5 / $25 / $40 Copay	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

Rev 08/2012

Benefit Riders: 599,573,301,259,126,124,039,016,012,482,K60

* 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.

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for
Detroit Public Schools

HENRY FORD PREFERRED NETWORK
STANDARD
CORE
PLAN

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:	HENRY FORD PREFERRED NETWORK	
Benefit Period:	Calendar Year	
Annual Deductible	$500 Individual ; $1,000 Family	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 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	
Specialty Physician Office Visit	$20 Copay - Deductible does not apply	
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	Covered after Deductible	
Laboratory and 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	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	$100 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$50 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 Health:		
Inpatient Services	Covered after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Chemical Dependency:		
Inpatient Services	Covered after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Other Services:		
Home Health Care	Covered after Deductible	UNLIMITED
Hospice Care	Covered after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Covered after Deductible	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Covered after Deductible	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Covered after Deductible	
Voluntary Termination of Pregnancy	Not Covered	
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	$5 / $25 / $40 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: 599,573,553,301,259,126,124,039,016,012,482,K60

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Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for
Detroit Public Schools

FULL HAP HMO NETWORK
PREMIUM PLAN

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:	FULL HAP HMO NETWORK	
Benefit Period:	Calendar Year	
Annual Deductible	$500 Individual ; $1,000 Family	
Co-insurance (amount member pays)	10%	
Annual Co-insurance Maximum	$500 Individual ; $1,000 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, penalties, deductibles, and copays
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 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	
Specialty Physician Office Visit	$20 Copay - Deductible does not apply	
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	Plan Pays 90% after Deductible	
Laboratory and Radiology Services	Plan Pays 90% after Deductible	
Dialysis	Plan Pays 90% after Deductible	
Chemotherapy	Plan Pays 90% after Deductible	
Radiation Therapy	Plan Pays 90% after Deductible	
Outpatient Surgery	Plan Pays 90% after Deductible	
Chiropractic Office Visit and Related Services	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	$100 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$50 Copay - Deductible does not apply	
Emergency Ambulance Services	Plan Pays 90% 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	Plan Pays 90% after Deductible	
Bariatric Surgery & Related Services	Plan Pays 90% 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	Plan Pays 90% after Deductible	
Mental Health:		
Inpatient Services	Plan Pays 90% after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Chemical Dependency:		
Inpatient Services	Plan Pays 90% after Deductible	
Outpatient Services	$20 Copay - Deductible does not apply	
Other Services:		
Home Health Care	Plan Pays 90% after Deductible	UNLIMITED
Hospice Care	Plan Pays 90% after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Plan Pays 90% after Deductible	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Plan Pays 90% after Deductible	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 90% after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 90% after Deductible	
Voluntary Termination of Pregnancy		
Infertility Services	Plan Pays 90% 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	Plan Pays 90% after Deductible	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	$5 / $25 / $40 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: K45,599,573,259,148,126,124,039,016,012,482,K60

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