

Schedule of Benefits

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

GROUP NUMBER:	10004779	GROUP NAME:	CLARKSTON COMMUNITY SCHOOLS HMO
PRODUCT ID:	AA002213 / XR001164	PRODUCT TYPE:	HMO
COVERAGE DATES:	07/01/2026 - 06/30/2027	BENEFIT PERIOD:	Fiscal Year
PLAN NAME:	AA002213 / XR001164		

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	\$500	N/A
• Family	\$1,000	N/A
Coinsurance	20%	N/A
Annual Coinsurance Maximum		
• Individual	\$1,500	N/A
• Family	\$3,000	N/A
Annual Out-of-Pocket Limit		
• Individual	\$6,600	N/A
• Family	\$13,200	N/A

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Preventive Services		
Routine Well Visits	Covered; Deductible does not apply	Not Covered
Related Laboratory and Radiology Services	Covered; Deductible does not apply	Not Covered
Pap smear, mammogram, tubal ligation	Covered; Deductible does not apply	Not Covered
Immunizations	Covered; Deductible does not apply	Not Covered

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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; Deductible does not apply	Not Covered
HAP Telehealth Through our Designated Telehealth Partner.	\$20 Copay per visit; Deductible does not apply	Not Covered
Specialist Office Visit Includes Physician home visits	\$40 Copay per visit; Deductible does not apply	Not Covered
Routine Audiology Exam One exam per benefit period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Eye Exam One exam per benefit period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Chiropractic Services Up to 20 visits per benefit period.	\$40 Copay per visit; Deductible does not apply	Not Covered
Allergy Treatment	20% Coinsurance after Deductible	Not Covered
Allergy Injections	20% Coinsurance after Deductible	Not Covered
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	Not Covered
Radiology (X-ray)	20% Coinsurance after Deductible	Not Covered
Radiation Therapy & Chemotherapy	20% Coinsurance after Deductible	Not Covered
Dialysis	20% Coinsurance after Deductible	Not Covered
Genetic Testing	20% Coinsurance after Deductible	Not Covered
Outpatient Medical Drugs	20% Coinsurance after Deductible	Not Covered

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Outpatient Hospital and Ambulatory Surgical Center Services		
Physician & Other Professional Services	20% Coinsurance after Deductible	Not Covered
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	Not Covered
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	Not Covered
Radiology (X-ray)	20% Coinsurance after Deductible	Not Covered
Outpatient Hospital Surgical Facility (OP Hosp)	20% Coinsurance after Deductible	Not Covered
Ambulatory Surgical Center (ASC)	20% Coinsurance after Deductible	Not Covered
Radiation Therapy & Chemotherapy	20% Coinsurance after Deductible	Not Covered
Dialysis	20% Coinsurance after Deductible	Not Covered
Emergency / Urgent Care		
Urgent Care	\$50 Copay per visit; Deductible does not apply	
Emergency Room Services Copay will be waived if admitted	\$150 Copay per visit; Deductible does not apply	
Emergency Medical Transportation Emergency Transport Only	20% Coinsurance after Deductible	
Inpatient Hospital Services		
Facility Fee	20% Coinsurance after Deductible	Not Covered
Physician Services, Surgery, Therapy & Other Hospital Services	20% Coinsurance after Deductible	Not Covered
Diagnostic & Laboratory Services • X-rays • Lab Tests • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	Not Covered
Bariatric Surgery & Related Services One procedure per lifetime	20% Coinsurance after Deductible	Not Covered
Maternity Services		
Routine Prenatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Postnatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Inpatient Hospital, Labor, Delivery & Newborn Care	20% Coinsurance after Deductible	Not Covered
Transplant Services		
Organ Transplant Surgery & Related Services	20% Coinsurance after Deductible	Not Covered

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HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Mental Health & Substance Use Disorder Services		
Inpatient Services	20% Coinsurance after Deductible	Not Covered
Outpatient Services	\$20 Copay per visit; Deductible does not apply	Not Covered
Autism Spectrum Disorder Services		
Physical, Occupational and Speech Therapy for Treatment of Autism Spectrum Disorder	20% Coinsurance after Deductible	Not Covered
Applied Behavioral Analysis for Treatment of Autism Spectrum Disorder	\$20 Copay per visit; Deductible does not apply	Not Covered
Other Services		
Home Health Care Does not include Rehabilitation Services. Unlimited.	20% Coinsurance after Deductible	Not Covered
Hospice Care Up to 210 days per lifetime	20% Coinsurance after Deductible	Not Covered
Skilled Nursing Facility Up to 100 days per benefit period.	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment (DME); Prosthetics & Orthotics Covered for approved equipment only.	20% Coinsurance after Deductible	Not Covered
Physical, Occupational & Speech Therapy May be rendered at home. Up to 60 combined visits per benefit period.	20% Coinsurance after Deductible	Not Covered
Temporomandibular Joint Disorder Coverage for non-invasive treatments only.	20% Coinsurance after Deductible	Not Covered
Orthognathic Surgery	20% Coinsurance after Deductible	Not Covered
Reproductive Care & Family Planning Services		
Voluntary Sterilizations Limited to vasectomy.	20% Coinsurance after Deductible	Not Covered
Fertility Preservation	Not Covered	Not Covered
Infertility Services Services for diagnosis, counseling & treatment of bodily disorders causing infertility.	20% Coinsurance after Deductible	Not Covered

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HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Additional Health Care Services		
Hearing Aid Hardware Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.	\$0 Copay per Hearing Aid for Value Technology Hearing Aids; Deductible does not apply \$689 Copay per Hearing Aid for Basic Technology Hearing Aids; Deductible does not apply \$989 Copay per Hearing Aid for Prime Technology Hearing Aids; Deductible does not apply \$1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids; Deductible does not apply \$2,039 Copay per Hearing Aid for Premium Technology Hearing Aids; Deductible does not apply	Not Covered
Assisted Reproductive Technologies One visit per lifetime	20% Coinsurance after Deductible	Not Covered

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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	\$5 Copay ;Deductible does not apply	\$10 Copay ;Deductible does not apply
Tier 2	\$5 Copay ;Deductible does not apply	\$10 Copay ;Deductible does not apply
Tier 3	\$25 Copay ;Deductible does not apply	\$50 Copay ;Deductible does not apply
Tier 4	\$50 Copay ;Deductible does not apply	\$100 Copay ;Deductible does not apply
Tier 5	\$50 Copay ;Deductible does not apply	Not Applicable**
Tier 6	\$50 Copay ;Deductible does not apply	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 5 & Tier 6 (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.

****For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

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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.