Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA000586 / XR000920

HMO
AA000586 / XR000920 / XW000317

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$0 Individual; $0 Family	N/A	
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$6,600 Individual; $13,200 Family	N/A	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.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered	N/A	
Related Laboratory and Radiology Services	Covered	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered	N/A	
Immunizations	Covered	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	Covered	N/A	
Telehealth Visit	Covered	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	Covered	N/A	
Routine Audiology Exam	Covered	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	Not Covered	N/A	
Allergy Treatment	Covered	N/A	
Allergy Injections	Covered	N/A	
Laboratory & Pathology	Covered	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered	N/A	Services require preauthorization.
Radiology (X-ray)	Covered	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered	N/A	
Dialysis	Covered	N/A	
Outpatient Medical Drugs	Covered	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered	N/A	
Ambulatory Surgical Center	Covered	N/A	
Professional Surgical and Related Services	Covered	N/A	
Emergency/Urgent Care			
Urgent Care	Covered		
Emergency Room Care	Covered		
Emergency Medical Transportation	Covered		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	N/A	
Bariatric Surgery and Related Services	$1,000 Copay	N/A	One procedure per lifetime
Maternity Services			
Routine Prenatal Office Visits	Covered	N/A	Covered under Preventive Services
Routine Postnatal Office Visits	Covered	N/A	Covered under Preventive Services
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered	N/A	
Other Services			
Home Health Care	Covered	N/A	Does not include Rehabilitation Services. Unlimited.
Hospice Care	Covered	N/A	Up to 210 days per lifetime
Skilled Nursing Care	Covered	N/A	Covered for authorized services. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	Not Covered	N/A	
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Covered	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered	N/A	One visit per lifetime
Temporomandibular Joint Disorder	Covered	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$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.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply		
Preferred Brand Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Non-Preferred Brand Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Preferred Specialty Drugs	$20 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$20 Copay 30 day supply at specialty pharmacy only		

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- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO 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.