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

UAW GM Protected

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	N/A	N/A	
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	$25 Copay	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	$25 Copay	N/A	
Telehealth Visit	$25 Copay	N/A	Through our contracted telehealth services provider. For Telehealth Visits for Mental Health & Substance Use Disorder see Mental Health & Substance Use Disorder Outpatient Services.
Specialist Office Visit	$25 Copay	N/A	
Routine Audiology Exam	$25 Copay	N/A	For non-routine visits see Specialist Office Visit
Routine Eye Exam	$25 Copay	N/A	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	$50 Copay		
Emergency Room Care	$100 Copay		Copay will be waived if admitted
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	Covered	N/A	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	$25 Copay	N/A	
Postnatal Office Visits	$25 Copay	N/A	
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	Includes visits through Our Contracted Telehealth Services Provider
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 100 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	Covered	N/A	
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids $689 Copay per Hearing Aid for Basic Technology Hearing Aids $989 Copay per Hearing Aid for Prime Technology Hearing Aids $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered	N/A	Covered once each 12 month period thru HAP's Contracted Providers. $80 benefit maximum for Frames/Lens or Contact Lens. Details can be found in your policy or plan documents.
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
Temporomandibular Joint Disorder	Covered	N/A	Coverage for non-invasive treatments only
Pharmacy - Not Covered			

* 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.