***Health Alliance Plan of Michigan***

**Health Maintenance Organization (HMO) Plan**

**Summary of Benefits**

**HMO**

**AA001747 / XR001580 / XW000628 QR-23320**

| 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, health care this plan doesn't cover. All other cost sharing accumulates. |
| **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 | $25 Copay | N/A | Home visit by physician is also covered when medically necessary |
| Telehealth Visit | $10 Copay | N/A | Through our contracted telehealth services provider. |
| Specialist Office Visit | $25 Copay | N/A | Home visit by physician is also covered when medically necessary |
| Audiology Office Visit | $25 Copay | N/A | One routine hearing exam per benefit period at no cost share |
| Eye Exam Office Visit | $25 Copay | N/A | One routine eye exam per benefit period at no cost share |
| 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 | |
| Chiropractic Services | Covered | N/A | Manipulation of the spine for subluxation only; Up to 20 visits per benefit period. |
| **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 or held for observation regardless of duration |
| 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 | Covered | N/A | Covered under Preventive Services. |
| Postnatal Office Visits | Covered | 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 | |
| **Other Services** | | | |
| Home Health Care | Covered | N/A | Unlimited; Does not include Rehabilitation Services. |
| Hospice Care | Covered | N/A | |
| Private Duty Nursing | Covered | N/A | Covered for authorized services |
| Skilled Nursing Care | Covered | N/A | Covered for authorized services |
| Durable Medical Equipment; Prosthetics & Orthotics | Covered | N/A | Coverage for approved equipment only |
| Hearing Aid Hardware | Covered | N/A | Covered for authorized equipment only |
| Vision Hardware | Covered | N/A | Coverage for one pair of eye glasses each 12-month consecutive period. Detailed information regarding coverage of lenses and Collections Frames 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 | Covered | N/A | Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount. |
| 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 | 1 attempt per lifetime |
| Temporomandibular Joint Disorder | Covered | N/A | Coverage for non-invasive treatments only. |
| **Pharmacy (Affiliated pharmacy providers only)** | | | |
| Preferred Generic Drugs | $6 Copay 30 day supply, $6 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. |
| Non-Preferred Generic Drugs | $6 Copay 30 day supply, $6 Copay 90 day supply | | |
| Preferred Brand Drugs | $13 Copay 30 day supply, $13 Copay 90 day supply | | |
| Non-Preferred Brand Drugs | $13 Copay 30 day supply, $13 Copay 90 day supply | | |
| Preferred Specialty Drugs | $13 Copay 30 day supply at specialty pharmacy only | | |
| Non-Preferred Specialty Drugs | $13 Copay 30 day supply at specialty pharmacy only | | |
| Erectile Dysfunction Drugs | $19 Copay 30 day supply, $19 Copay 90 day supply | | |

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- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP 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.
- 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.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.