



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

**HAP HMO Custom 429 / XR001591**

**HMO  
XR001591**

<b>Health Care Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Limitations</b>
<b>Plan Attributes</b>			
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.
<b>Preventive Services</b>			
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	
<b>Outpatient &amp; Physician Services</b>			
Primary Care Office Visit	\$25 Copay	N/A	
Telehealth Visit	\$12.50 Copay	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	\$25 Copay	N/A	
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	\$25 Copay	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period
<b>Outpatient Surgical Services</b>			
Outpatient Surgery	Covered	N/A	
Ambulatory Surgical Center	Covered	N/A	
Professional Surgical and Related Services	Covered	N/A	
<b>Emergency/Urgent Care</b>			
Urgent Care	\$50 Copay		
Emergency Room Care	\$100 Copay		Copay will be waived if admitted
Emergency Medical Transportation	Covered		Emergency transport only
<b>Inpatient Hospital Services</b>			
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
<b>Maternity Services</b>			
Prenatal Office Visits	Covered	N/A	Covered under Preventive Services
Postnatal Office Visits	\$25 Copay	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

<b>Mental Health &amp; Substance Use Disorder</b>			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered	N/A	
<b>Other Services</b>			
Home Health Care	Covered	N/A	Does not include Rehabilitation Services; Unlimited
Hospice Care	Covered	N/A	Unlimited
Skilled Nursing Care	Covered	N/A	Covered for authorized services; Unlimited
Durable Medical Equipment; Prosthetics & Orthotics	Covered	N/A	Covered for approved equipment only.
Hearing Aid Hardware	Covered	N/A	Covered for approved equipment only
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	One attempt per lifetime
Temporomandibular Joint Disorder	Covered	N/A	Coverage for non-invasive treatments only.
<b>Pharmacy (Affiliated pharmacy providers only)</b>			
Preferred Generic Drugs	\$6 Copay 30 day supply, \$12 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, \$12 Copay 90 day supply		
Preferred Brand Drugs	\$12 Copay 30 day supply, \$17 Copay 90 day supply		
Non-Preferred Brand Drugs	\$12 Copay 30 day supply, \$17 Copay 90 day supply		
Preferred Specialty Drugs	\$12 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	\$12 Copay 30 day supply at specialty pharmacy only		
Erectile Dysfunction Drugs	\$17 Copay 30 day supply, \$21 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.