Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits - UAW Trust Chrysler General (AA001695)

Health Care Services	In-Network	Limitations
Plan Attributes		
Benefit Period	Calendar Year	
Annual Deductible	$400 Individual; $675 Family	Deductible does not include copays or coinsurance
Coinsurance	0%	
Annual Coinsurance Maximum	N/A	
Annual Out-of-Pocket Maximum	$0 Individual; $0 Family	
Preventive Services		
Office Visit, Physical Exam, Well Baby Exam	$25 Copay – Deductible does not apply	
Related Laboratory and Radiology Services	Covered – Deductible does not apply	
Pap Smear, Mammogram, Tubal Ligation	Covered – Deductible does not apply	
Immunizations	Covered – Deductible does not apply	
Outpatient & Physician Services		
Primary Care Office Visit	$25 Copay – Deductible does not apply	
Telehealth Visit	$25 Copay – Deductible does not apply	Through our contracted telehealth services provider
Specialist Office Visit	$35 Copay – Deductible does not apply	
Gynecology Office Visit	$35 Copay – Deductible does not apply	
Audiology Office Visit	$35 Copay – Deductible does not apply	One routine hearing exam per benefit period at no cost share
Eye Exam Office Visit	$25 Copay – Deductible does not apply	One routine eye exam per benefit period at no cost share
Allergy Treatment	Covered after deductible	
Allergy Injections	Covered after deductible	
Laboratory and Pathology	Covered after deductible	
Imaging MRI, CT and PET Scans	Covered after deductible	
Radiology (X-ray)	Covered after deductible	
Radiation Therapy and Chemotherapy	Covered after deductible	
Dialysis	Covered after deductible	
Outpatient Surgery	Covered after deductible	
Chiropractic Services	Not covered	
Emergency/Urgent Care		
Urgent Care	$50 Copay – Deductible does not apply	
Emergency Room Care	$125 Copay – Deductible does not apply	Copay will be waived if admitted
Emergency Medical Transportation	Covered after deductible	Emergency transport only
Inpatient Hospital Services		
Facility Fee	Covered after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	
Bariatric Surgery and Related Services	Covered after deductible	One procedure per lifetime
Maternity Services		
Prenatal Office Visits	$35 Copay – Deductible does not apply	Covered under Preventive Services
Postnatal Office Visits	$35 Copay – Deductible does not apply	
Labor, Delivery and Newborn Care	See Inpatient Hospital Services	

Mental Health & Substance Use Disorder		
Inpatient Services	See Inpatient Hospital Services	
Outpatient Services	$25 Copay – Deductible does not apply	
Other Services		
Home Health Care	Covered after deductible	Unlimited; does not include Rehabilitation Services
Hospice Care	Covered after deductible	Up to 210 days per lifetime
Skilled Nursing Care	Covered after deductible	Covered for authorized services; maximum benefits 100 days per benefit period. Maximum benefit renews after 60-day nonconfinement. See plan for further details.
Durable Medical Equipment, Prosthetics and Orthotics	Covered – Deductible does not apply	Coverage for approved equipment only
Hearing Aid Hardware	Covered after deductible	Covered for authorized equipment only
Vision Hardware	Covered – Deductible does not apply	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection frames can be found in your policy or plan documents.
Rehabilitation Services: Physical, Occupational and Speech Therapy	Covered after deductible	May be rendered at home; up to 60 combined visits per benefit period
Habilitation Services	Covered after deductible	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 cost sharing amount.
Voluntary Sterilizations	Covered after deductible	Limited to vasectomy
Infertility Services	Covered after deductible	Services for diagnosis, counseling and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	
Pharmacy – Not Covered		

Benefit Riders: H00T, HMHE, HL04, HK10, H696, H526, H259, H148, H124, H081, H014, H013

- 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.