Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits - UAW Trust GM General
AA001694

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$400 Individual; $675 Family	N/A	Deductible does not include copays or coinsurance.
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 - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay - Deductible does not apply	N/A	
Telehealth Visit	$25 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$35 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$35 Copay - Deductible does not apply	N/A	
Eye Exam Office Visit	$25 Copay - Deductible does not apply	N/A	
Chiropractic Services	Not Covered	N/A	
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related	Covered after deductible	N/A	
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	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	$35 Copay - Deductible does not apply	N/A	
Postnatal Office Visits	$35 Copay - Deductible does not apply	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 - Deductible does not apply	N/A	
Other Services			
Home Health Care	Covered after deductible	N/A	Does not include Rehabilitation Services; Unlimited.
Hospice Care	Covered after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	Covered after deductible	N/A	Covered for authorized services; Up to 100 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	Covered - Deductible does not apply	N/A	Covered for approved equipment only.; Blood glucose monitors, insulin infusion pumps and associated supplies at no cost-share.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids - Deductible does not apply $689 Copay per Hearing Aid for Basic Technology Hearing Aids - Deductible does not apply $989 Copay per Hearing Aid for Prime Technology Hearing Aids - Deductible does not apply $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids - Deductible does not apply $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids - Deductible does not apply	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 - Deductible does not apply	N/A	Covered once each 12-consecutive month period. Limited to Collection Frames or Collection Contact Lenses.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	Covered after deductible	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 after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy - Not Covered			

Value Plus

- 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.