

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

## AAS00109 / XR001580 / XW000628

НМО

## AAS00109 / XR001580 / XW000628

Preventive Services  Office Vist I Pysical Exam / Well Baby Exam  Related Laboratory and Radiology Services  Outpatient & Physical Exam / Well Baby Exam  Related Laboratory and Radiology Services  Outpatient & Physician Services  Outpatient & Physician Services  Telehealth Visit  Specialist Office Visit Visit  Specialist Office Visit Scopey  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  Specialist Office Visit  Specialist Office Visit  Specialist Office Visit  Specialist Office Visit  Routine Audiology Exam  Covered  N/A  Routine Audiology Exam  Covered  N/A  Allergy Trestment  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Covered  N/A  Some services require preauthorization.  Radiology (K-ray)  Radiology (K-ray)  Radiology Covered  N/A  Covered  N/A  Covered  N/A  Services require preauthorization.  Radiology (K-ray)  Radiology (K-ray)  Covered  N/A  Covered  N/A  Covered  N/A  Covered  N/A  Services require preauthorization.  Radiology (K-ray)  Radiology (K-ray)  Routine Surgices  Covered  N/A  Covered	Health Care Services	In-Network	Out-of-Network	Limitations
Annual Deduzible \$0 Individual; \$0 Family N/A	Plan Attributes			
Coinsurance Maximum N/A Annual Coinsurance Maximum N/A Annual Coinsurance Maximum N/A Annual Coinsurance Maximum S6.600 Individual; \$13,200 Family N/A Annual Out-of-Pocket Maximum S6.600 Individual; \$13,200 Family N/A Annual Out-of-Pocket Maximum N/A Annual Out-of-Pocket Maximum S6.600 Individual; \$13,200 Family N/A Dalhace billed charges, and health care this doesn't cover. All other cost sharing accumula unless otherwise specified.  Preventive Services Office Visit Physicial Exam / Well Baby Exam Covered N/A Pag Smear, Marmogram, Tubal Ligation Immunizations Covered N/A Outpatient & Physician home visits when Medica Nocessary and Prior Authorized.  Telehealth Visit S10 Copay N/A Provider.  Telehealth Visit S10 Copay N/A Nocessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Nocessary and Prior Authorized.  Routine Audiology Exam Covered N/A Nocessary and Prior Authorized.  Routine Audiology Exam Covered N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services N/A Nocessary and Prior Authorized.  Chriopractic Services S26 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services N/A Nocessary and Prior A	Benefit Period	Calendar Year		
Coinsurance Maximum N/A Annual Coinsurance Maximum N/A Annual Coinsurance Maximum N/A Annual Coinsurance Maximum S6.600 Individual; \$13,200 Family N/A Annual Out-of-Pocket Maximum S6.600 Individual; \$13,200 Family N/A Annual Out-of-Pocket Maximum N/A Annual Out-of-Pocket Maximum S6.600 Individual; \$13,200 Family N/A Dalhace billed charges, and health care this doesn't cover. All other cost sharing accumula unless otherwise specified.  Preventive Services Office Visit Physicial Exam / Well Baby Exam Covered N/A Pag Smear, Marmogram, Tubal Ligation Immunizations Covered N/A Outpatient & Physician home visits when Medica Nocessary and Prior Authorized.  Telehealth Visit S10 Copay N/A Provider.  Telehealth Visit S10 Copay N/A Nocessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Nocessary and Prior Authorized.  Routine Audiology Exam Covered N/A Nocessary and Prior Authorized.  Routine Audiology Exam Covered N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services S25 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services N/A Nocessary and Prior Authorized.  Chriopractic Services S26 Copay N/A Nocessary and Prior Authorized.  Chriopractic Services N/A Nocessary and Prior A	Annual Deductible	\$0 Individual; \$0 Family	N/A	
Annual Out-of-Pocket Maximum  \$6,600 Individual: \$13,200 Family  N/A  balance-billed charges, and health care this is doesn't cover. All other cost sharing accumula unless otherwise specified.  Preventive Services  Covered  N/A  Related Laboratory and Radiology Services  Pag Smear, Mammogram, Tubal Ligation Immunizations  Covered  N/A  Pirmary Care Office Visit  Telehealth Visit  S10 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  S10 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  S25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  S26 Copay  N/A  Routine Audiology Exam  Covered  N/A  Novered  N/A  Routine Audiology Exam  Covered  N/A  Novered  N/A  Novered  N/A  Covered  N/A  Novered  N/A  Some services require preauthorization.  Radiotory (X-ray)  Radiotory (X	Coinsurance	· · · · · · · · · · · · · · · · · · ·	N/A	
Annual Out-of-Pocket Maximum \$6,600 Individual; \$13,200 Family N/A balnace-billed charges, and health care this is doesn't cover. All other cost sharing accumula unless otherwise specified.  Preventive Services  Covered N/A Related Laboratory and Radiology Services Pag Smear, Mammogram, Tubal Ligation Covered N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized.  Routine Audiology Exam Covered N/A N/A Necessary and Prior Authorized.  Routine Exp Exam Covered N/A	Annual Coinsurance Maximum	N/A	N/A	
Office Visit / Physical Exam / Well Baby Exam Related Laboratory and Radiology Services Related Laboratory and Radiology Covered N/IA Pap Smear, Mammogram, Tubal Ligation Covered N/IA Immunizations N/IA Immunizations N/IA Immunizations N/IA Includes Physician services Primary Care Office Visit \$25 Copay N/IA Includes Physician home visits when Medica Necessary and Prior Authorized. Telehealth Visit \$10 Copay N/IA Necessary and Prior Authorized. Telehealth Visit \$10 Copay N/IA Includes Physician home visits when Medica Necessary and Prior Authorized. Telehealth Visit \$10 Copay N/IA Includes Physician home visits when Medica Necessary and Prior Authorized. Telehealth Visit \$25 Copay N/IA Includes Physician home visits when Medica Necessary and Prior Authorized. Through our contracted telehealth services provider.  Specialist Office Visit \$25 Copay N/IA Includes Physician home visits when Medica Necessary and Prior Authorized.  Routine Audiology Exam Covered N/IA One exam per Benefit Period. For non-routing visits see Specialist Office Visit. Chiropractic Services \$25 Copay N/IA (Septimental Concessary and Prior Authorized).  Chiropractic Services \$25 Copay N/IA (Septimental Concessary and Prior Authorized).  Allergy Treatment Covered N/IA Manipulation of the spine for subluxation only to 20 visits per benefit period.  Allergy Injections Covered N/IA Some services require preauthorization.  Radiology (X-ray) Covered N/IA Services require preauthorization.  Remargency/Urgent Care Secured N/IA Services require preauthorization.  Remargency/Urgent Care Secu	Annual Out-of-Pocket Maximum	\$6,600 Individual; \$13,200 Family	N/A	balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates
Exam Related Laboratory and Radiology Services Covered N/A Pap Smear, Mammogram, Tubal Ligation Covered N/A Immunizations Covered N/A  Vicational Services Primary Care Office Visit S25 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized. Telehealth Visit S10 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized. Telehealth Visit S10 Copay N/A Includes Physician home visits when Medica Necessary and Prior Authorized. Through our contracted telehealth services provider. Specialist Office Visit S25 Copay N/A N/A Includes Physician home visits when Medica Necessary and Prior Authorized. N/A N/A Specialist Office Visit S25 Copay N/A	Preventive Services			
Services  Covered  N/A  Immunizations  Covered  N/A  Outpatient & Physician Services  Primary Care Office Visit  Services  Primary Care Office Visit  Sepcialist Office Visit  N/A  Covered  N/A  N/A  Sepecialist Office Visit  Sepcialist Office Visit  N/A  Sepcialist Office Visit  Sepcialist Office Visit  Sepcialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  Sepcialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Sepcialist Office Visit  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist Feriod, For non-routin visits see Specialist Office Visit  N/A  Sepcialist		Covered	N/A	
Immunizations  Outpatient & Physician Services  Primary Care Office Visit  S25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  S10 Copay  N/A  Through our contracted telehealth services provider.  Specialist Office Visit  S25 Copay  N/A  N/A  None exam per Benefit Period. For non-routin visits see Specialist Office Visit  Routine Audiology Exam  Covered  N/A  None exam per Benefit Period. For non-routin visits see Specialist Office Visit see Specialist Office Visit  Routine Eye Exam  Covered  N/A  None exam per Benefit Period. For non-routin visits see Specialist Office Visit visits see Specialist Office Visit  Chiropractic Services  S25 Copay  N/A  Manipulation of the spine for subluxation only to 20 visits per benefit period.  Allergy Treatment  Covered  N/A  Allergy Injections  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Some services require preauthorization.  Radiotogy (X-ray)  Radiotogy (X-ray)  Radiotogy (X-ray)  Radiotan Therapy & Chemotherapy  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Surgical Services  Outpatient Surgical and Related Services  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Fortessional Surgical and Related Services  Covered  N/A  Emergency/Urgent Care  Urgent Care  S50 Copay  Emergency/Urgent Care  Urgent Care  S50 Copay  Emergency Modical Transportation  Covered  N/A  Emergency It and the wive of admitted or held for observation regardless of duration  Emergency Room Care  Emergency Modical Transportation  Covered  N/A  Physician Services, Surgery, Therapy,  Laboratory, Radiology, Hospital Services  Covered  N/A	,	Covered	N/A	
Outpatient & Physician Services  Primary Care Office Visit  \$25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  \$10 Copay  N/A  Through our contracted telehealth services provider.  Specialist Office Visit  \$25 Copay  N/A  Necessary and Prior Authorized.  Through our contracted telehealth services provider.  Specialist Office Visit  \$25 Copay  N/A  Necessary and Prior Authorized.  Necessary and Prior Authorized.  Routine Audiology Exam  Covered  N/A  One exam per Benefit Period. For non-routinvisits see Specialist Office Visit.  Routine Eye Exam  Covered  N/A  One exam per Benefit Period. For non-routinvisits see Specialist Office Visit.  Chiropractic Services  \$25 Copay  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Some services require preauthorization.  Radiation Therapy & Chemotherapy  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Some services require preauthorization.  Radiation Therapy & Chemotherapy  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Some services require preauthorization.  Radiation Therapy & Chemotherapy  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injection	Pap Smear, Mammogram, Tubal Ligation	Covered	N/A	
Primary Care Office Visit  Primary Care Office Visit  \$25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  \$10 Copay  N/A  Through our contracted telehealth services provider.  Specialist Office Visit  \$25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Noe exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Routine Audiology Exam  Covered  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Routine Eye Exam  Covered  N/A  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Chiropractic Services  \$25 Copay  N/A  Allergy Treatment  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Services require preauthorization.  Radiology (X-ray)  Covered  N/A  Salvices require preauthorization.  Radiology (X-ray)  Covered  N/A  Dialysis  Covered  N/A  Outpatient Surgical Services  Outpatient Surgical Center  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Covered  N/A  Manipulation of the spine for subluxation only to 20 visits per benefit period.  N/A  Services require preauthorization.  Services require preauthorization.  N/A  Services require preauthorization.  N/A  Some services require preauthorization.  N/A  N/A  Outpatient Medical Drugs  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Manipulation of the spine for subluxation only to 20 visits per benefit period.  Covered  N/A  Mola Visits see Specialist Office Visit.  N/A  N/A  Some services require preauthorization.  Covered  N/A  N/A  Covered  N/A  Expressional Surgical and Related Services  Covered  N/A  Emergency Medical Transportation  Covered  Emergency Medical Transportation  Covered  Emergency Medical Transportation  Covered  N/A  Emergency Me	Immunizations	Covered	N/A	
Primary Care Office Visit  Primary Care Office Visit  \$25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Telehealth Visit  \$10 Copay  N/A  Through our contracted telehealth services provider.  Specialist Office Visit  \$25 Copay  N/A  Includes Physician home visits when Medica Necessary and Prior Authorized.  Noe exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Routine Audiology Exam  Covered  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Routine Eye Exam  Covered  N/A  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Chiropractic Services  \$25 Copay  N/A  Allergy Treatment  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Services require preauthorization.  Radiology (X-ray)  Covered  N/A  Salvices require preauthorization.  Radiology (X-ray)  Covered  N/A  Dialysis  Covered  N/A  Outpatient Surgical Services  Outpatient Surgical Center  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Covered  N/A  Manipulation of the spine for subluxation only to 20 visits per benefit period.  N/A  Services require preauthorization.  Services require preauthorization.  N/A  Services require preauthorization.  N/A  Some services require preauthorization.  N/A  N/A  Outpatient Medical Drugs  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Manipulation of the spine for subluxation only to 20 visits per benefit period.  Covered  N/A  Mola Visits see Specialist Office Visit.  N/A  N/A  Some services require preauthorization.  Covered  N/A  N/A  Covered  N/A  Expressional Surgical and Related Services  Covered  N/A  Emergency Medical Transportation  Covered  Emergency Medical Transportation  Covered  Emergency Medical Transportation  Covered  N/A  Emergency Me	Outpatient & Physician Services			
I elementarity visit  Specialist Office Visit  Specialist Office Visit  Routine Audiology Exam  Covered  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/	Primary Care Office Visit	\$25 Copay	N/A	Includes Physician home visits when Medically Necessary and Prior Authorized.
Routine Audiology Exam  Covered  N/A  Necessary and Prior Authorized.  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Routine Eye Exam  Covered  N/A  N/A  One exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Chiropractic Services  \$25 Copay  N/A  Allergy Treatment  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Covered  N/A  Allergy Pathology  Covered  N/A  Radiology (X-ray)  Covered  N/A  Radiology (X-ray)  Covered  N/A  Some services require preauthorization.  Radiology (X-ray)  Covered  N/A  N/A  Some services require preauthorization.  Radiology (X-ray)  Covered  N/A  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Surgery  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Professional Surgical and Related Services  Covered  N/A  Professional Surgical and Related Services  Covered  Sino Copay  Copay will be waived if admitted or held for observation regardless of duration  Emergency Medical Transportation  Covered  N/A  Professional Surgical Services  Copay will be waived if admitted or held for observation regardless of duration  Emergency Room Care  Sino Copay  Copay will be waived if admitted or held for observation regardless of duration  Emergency Medical Transportation  Covered  N/A  N/A  N/A  Professional Surgical Services  Facility Fee  Covered  N/A  N/A  N/A  N/A  N/A  N/A  Professional Surgical Services  Facility Fee  Covered  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/	Telehealth Visit	\$10 Copay	N/A	
Routine Eye Exam  Covered  N/A  visits see Specialist Office Visit.  Routine Eye Exam  Covered  N/A  N/A  Cone exam per Benefit Period. For non-routine visits see Specialist Office Visit.  Chiropractic Services  \$25 Copay  N/A  Allergy Treatment  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Allergy Injections  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Radiology (X-ray)  Radiology (X-ray)  Radiology (X-ray)  Covered  N/A  Some services require preauthorization.  Radiology (X-ray)  Radiology (X-ray)  Covered  N/A  Some services require preauthorization.  Radiology (X-ray)  Radiology (X-ray)  Radiology (X-ray)  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Ambulatory Surgical Services  Covered  N/A  Ambulatory Surgical Center  Covered  N/A  Professional Surgical and Related Services  Emergency/Urgent Care  Urgent Care  \$50 Copay  Emergency Medical Transportation  Covered  N/A  Physician Services  Covered  N/A	Specialist Office Visit	\$25 Copay	N/A	Includes Physician home visits when Medically Necessary and Prior Authorized.
Covered N/A visits see Specialist Office Visit.  Chiropractic Services \$25 Copay N/A Manipulation of the spine for subluxation only to 20 visits per benefit period.  Allergy Treatment Covered N/A  Allergy Injections Covered N/A  Laboratory & Pathology N/A Some services require preauthorization.  Radiology (X-ray) Covered N/A Services require preauthorization.  Radiology (X-ray) Covered N/A Some services require preauthorization.  Radiology (X-ray) Covered N/A Some services require preauthorization.  Radiation Therapy & Chemotherapy Covered N/A Some services require preauthorization.  Radiation Therapy & Chemotherapy Covered N/A Some services require preauthorization.  Radiation Therapy & Covered N/A Covered Soveration regardless of duration regardless of duration regardless of duration Emergency Medical Transportation Covered Emergency Medical Transportation Covered Emergency Medical Transportation Covered Emergency Sourgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A Laboratory, Radiology, Hospital Services Covered N/A	Routine Audiology Exam	Covered	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Correct Services \$25 Copay   N/A to 20 visits per benefit period.  Allergy Treatment   Covered   N/A   Allergy Injections   Covered   N/A   Analysis   Covered   N/A   Allergy Injections   Covered   N/A   Activities require preauthorization.  Radiation Therapy & Chemotherapy   Covered   N/A   Dialysis   Covered   N/A   Outpatient Medical Drugs   Covered   N/A   Outpatient Surgical Services  Outpatient Surgical Services  Outpatient Surgical Center   Covered   N/A   Ambulatory Surgical Center   Covered   N/A   Ambulatory 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   N/A   Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services   Covered   N/A   Physician Services   Covered   N/A   Physician Services   Covered   N/A   Pressional Services   Covered   N/A   Pressional Services   Covered   N/A   Physician S	Routine Eye Exam	Covered	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Allergy Injections  Covered  N/A  Laboratory & Pathology  Covered  N/A  Some services require preauthorization.  Imaging MRI, CT & PET Scans  Covered  N/A  Radiology (X-ray)  Radiology (X-ray)  Covered  N/A  Radiation Therapy & Chemotherapy  Covered  N/A  Dialysis  Covered  N/A  Outpatient Medical Drugs  Covered  N/A  Outpatient Surgical Services  Outpatient Surgical Services  Outpatient Surgical Center  Covered  N/A  Professional Surgical and Related Services  Covered  N/A  Emergency/Urgent Care  Urgent Care  Emergency Room Care  Emergency Medical Transportation  Covered  N/A  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services  Covered  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/	Chiropractic Services	\$25 Copay	N/A	Manipulation of the spine for subluxation only. Up to 20 visits per benefit period.
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 Sono Copay Emergency Medical Transportation Covered Emergency Medical Transportation Covered N/A  Professional Services Covered N/A  Some services require preauthorization. N/A  N/A  Some services require preauthorization. N/A  N/A  Some services require preauthorization.	Allergy Treatment	Covered	N/A	
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  Professional Surgical and Related Services  Covered  N/A  Emergency/Urgent Care  Urgent Care  Urgent Care  \$50 Copay  Emergency Room Care  \$100 Copay  Covered  N/A  Emergency Medical Transportation  Covered  Sample Services  Facility Fee  Covered  N/A  N/A  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services  Covered  N/A  N/A	Allergy Injections	Covered	N/A	
Radiology (X-ray)  Radiology (A-ray)  Radiology (A-	Laboratory & Pathology	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 Professional Surgical and Related Services Covered N/A Emergency/Urgent Care Urgent Care Urgent Care Emergency Room Care S50 Copay Emergency Medical Transportation Covered Emergency Medical Transportation Covered N/A Emergency Room Care S100 Copay Emergency Medical Transportation Covered Emergency Room Care Facility Fee N/A Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Imaging MRI, CT & PET Scans	Covered	N/A	Services require preauthorization.
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 or held for observation regardless of duration Emergency Medical Transportation Covered N/A  Inpatient Hospital Services Facility Fee Covered N/A  Professional Surgical and Related Services Covered N/A  Copay will be waived if admitted or held for observation regardless of duration Emergency Medical Transportation N/A  Emergency Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Radiology (X-ray)	Covered	N/A	Some services require preauthorization.
Outpatient Medical Drugs Covered N/A  Outpatient Surgical Services  Outpatient Surgery Covered N/A  Ambulatory Surgical Center Professional Surgical and Related Services Covered N/A  Emergency/Urgent Care Urgent Care Urgent Care  Emergency Room Care S50 Copay  Emergency Medical Transportation Emergency Medical Transportation Covered Inpatient Hospital Services Facility Fee Covered N/A  N/A  N/A  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A  N/A	Radiation Therapy & Chemotherapy	Covered	N/A	
Outpatient Surgical Services         Outpatient Surgical Surgical Center       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       Covered       N/A	Dialysis	Covered	N/A	
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 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 Covered N/A  N/A	Outpatient Medical Drugs	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 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 Covered N/A	Outpatient Surgical Services			
Professional Surgical and Related Services Covered N/A  Emergency/Urgent Care  Urgent Care \$50 Copay  Emergency Room Care \$100 Copay Copay Copay Understand Professional Surgical Services  Emergency Medical Transportation Covered Emergency transport only.  Inpatient Hospital Services  Facility Fee Covered N/A  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Outpatient Surgery	Covered	N/A	
Emergency/Urgent Care  Urgent Care  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  Covered  N/A	Ambulatory Surgical Center	Covered	N/A	
Urgent Care \$50 Copay  Emergency Room Care \$100 Copay 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 Covered N/A	Professional Surgical and Related Services	Covered	N/A	
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 Covered N/A	Emergency/Urgent Care			
Emergency Room Care \$100 Copay 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 Covered N/A	Urgent Care	\$50 Copay		
Inpatient Hospital Services Facility Fee Covered N/A Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Emergency Room Care	\$100 Copay		
Facility Fee Covered N/A  Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Emergency Medical Transportation	Covered		
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services Covered N/A	Inpatient Hospital Services			
Laboratory, Radiology, Hospital Services Covered N/A	Facility Fee	Covered	N/A	
and Supplies		Covered	N/A	
Bariatric Surgery and Related Services Covered N/A One procedure per lifetime		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	Does not include Rehabilitation Services. Unlimited.			
Hospice Care	Covered	N/A	Unlimited.			
Private Duty Nursing	Covered	N/A	Covered for authorized services			
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	\$0 Copay per Hearing Aid for Value Technology Hearing Aids \$689 Copay per Hearing Aid for Basic 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.			
	\$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					
Vision Hardware	Covered	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	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.			
Assisted Reproductive Technologies	Covered	N/A	One 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 da		A 90-day supply of non-maintenance drugs must			
Non-Preferred Generic Drugs	\$6 Copay 30 day supply, \$6 Copay 90 da		be filled at our designated mail order pharmacy.  Other exclusions & limitations may apply.			
Preferred Brand Drugs	\$13 Copay 30 day supply, \$13 Copay 90 d	Outer exclusions α inflications may apply.				
Non-Preferred Brand Drugs	\$13 Copay 30 day supply, \$13 Copay 90 d	Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.				
Preferred Specialty Drugs	\$13 Copay 30 day supply at specialty phar					
Non-Preferred Specialty Drugs	\$13 Copay 30 day supply at specialty phar					
Erectile Dysfunction Drugs	\$19 Copay 30 day supply, \$19 Copay 90 day supply					

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- 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
- 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.