Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
HAP HMO Custom 303 / Rx HMO Custom 303 NSO

HMO
AAS00108 / XRS02904

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,200 Individual; $2,400 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	$2,000 Individual; $4,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, deductibles, services with 50% coinsurance, copays, and health care this plan doesn't cover.
Annual Out-of-Pocket Maximum	$6,600 Individual; $13,200 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
Telehealth Visit	$10 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay - Deductible does not apply	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$40 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only. Up to 20 visits per benefit period.
Allergy Treatment	20% Coinsurance after Deductible	N/A	
Allergy Injections	20% Coinsurance after Deductible	N/A	
Laboratory & Pathology	20% Coinsurance after Deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after Deductible	N/A	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after Deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after Deductible	N/A	
Dialysis	20% Coinsurance after Deductible	N/A	
Outpatient Medical Drugs	20% Coinsurance after Deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after Deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after Deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after Deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$75 Copay - Deductible does not apply		
Emergency Room Care	$250 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	20% Coinsurance after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after Deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after Deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after Deductible	N/A	One procedure per lifetime
Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
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	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	20% Coinsurance after Deductible	N/A	Does not include Rehabilitation Services. Up to 100 visits per benefit period.
Hospice Care	20% Coinsurance after Deductible	N/A	Unlimited.
Skilled Nursing Care	20% Coinsurance after Deductible	N/A	Covered for authorized services. Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after Deductible	N/A	Covered for approved equipment only.
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 month period thru HAP's Contracted Providers. $80 benefit maximum for Frames/Lens or Contact Lens. Details can be found in your policy or plan documents.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$20 Copay - Deductible does not apply	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	20% Coinsurance after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	20% Coinsurance after Deductible	N/A	One attempt per lifetime
Temporomandibular Joint Disorder	20% Coinsurance after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$7 Copay 30 day supply, $14 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. 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.
Non-Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Preferred Brand Drugs	$30 Copay 30 day supply, $60 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	20% Coinsurance ($200 max) 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	50% Coinsurance ($200 max) 30 day supply at specialty pharmacy only		

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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 or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.