Health Alliance Plan of Michigan

Health Maintenance Organization (HMO) Plan

Summary of Benefits

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	Covered up to 24 months
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$20 Copay	
Specialty Physician Office Visit	$20 Copay	
Gynecology Office Visit	$20 Copay	
Audiology Office Visit	$20 Copay	
Eye Exam Office Visit	$20 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	$20 Copay	Up to 10 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$150 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$20 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	$20 Copay	
Subsequent Prenatal and Postnatal Office Visits	$20 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental Health:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Chemical Dependency:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Other Services:		
Home Health Care	Covered	See PT/OT/ST Coverage
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Covered	Covered for authorized equipment
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Covered	
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	$5 / $25 / $50 Copay	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

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Benefit Code / Riders: LM6 / 012,013,016,118,124,126,133,201,573,920

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours 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. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.