



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

Health Care Services	Coverage	Limitations / Remarks
Benefit Period, Annual Deductible, and Annual Coinsurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Coinsurance (amount claimant pays)	None	
Annual Coinsurance Maximums	NA	
Preventive Services:		
Preventive Office Visit	\$20 Co-pay	
Well Baby Exam	\$20 Co-pay	
Immunization	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Primary Care Office Visit	\$20 Co-pay	
Specialty Physician Office Visit	\$20 Co-pay	
Gynecology	\$20 Co-pay	
Audiology Examinations	\$20 Co-pay	
Eye Examinations	\$20 Co-pay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation	Covered	
Outpatient/Office Surgery & Related Services	Covered	
Chiropractic Services	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	\$50 Co-pay	
Urgent Care Facility Services	Covered	
Emergency Ambulance Services	Covered	
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 Co-pay	
Maternity Services:		
Initial Office Visit to Confirm Pregnancy	\$20 Co-pay	
Subsequent Prenatal and Postnatal Office Visits	\$20 Co-pay	
Delivery and Nursery care	Covered	
Mental Health:		
Inpatient Services	Covered	Up to 45 days, renewable after 60 days
Outpatient Services	\$20 Co-pay	Up to 20 visits per benefit period
Chemical Dependency:		
Inpatient Services	Covered	Up to 45 days, renewable after 60 days or State mandated annual aggregate dollar amount whichever is greater
Outpatient Services	\$20 Co-pay	Up to 35 visits per benefit period or State mandated annual aggregate dollar amount, whichever is greater
Other Services:		
Home Health Care	Covered	
Hospice Care	Covered	210 days lifetime
Skilled Nursing Care	Covered	Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Covered	Coverage provided for authorized equipment
Hearing Aid (Hardware)	Covered	Covered for authorized conventional hearing aids
Vision Care Services (Hardware)	Not Covered	
Physical, Speech and Occupational Therapy	Covered	Up to 60 combined visits per benefit period
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 / Brand	\$10 / \$30 Co-pay	Retail: 30 day supply for non-maintenance drugs at 1 co-pay; 90 day supply for eligible maintenance drugs at 2 co-pays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 co-pays

Benefit Code / Riders: JFV / 012,013,016,034,037,112,124,126,423

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