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

HAP HMO Gold 1200 **HMO**

AAQ03232 / XRQ02774

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	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$7,000 Individual; $14,000 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	$35 Copay - Deductible does not apply	N/A	
Telehealth Visit	Covered - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$60 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	$30 Copay - Deductible does not apply	N/A	Manipulation of spine for subluxation only. Up to 20 visits per benefit period.
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	$45 Copay per test - Deductible does not apply	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	$45 Copay per test - Deductible does not apply	N/A	
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Outpatient Medical Drugs	20% Coinsurance 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 Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$65 Copay - Deductible does not apply		
Emergency Room Care	$300 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay - Deductible does not apply		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			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Service. For non-routine visits see Specialist Office Visit.
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	$35 Copay - 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	Unlimited.
Skilled Nursing Care	Covered after deductible	N/A	Covered for authorized services. Up to 45 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	N/A	Covered for approved equipment only.
Vision Hardware	Covered - Deductible does not apply	N/A	Covered once each benefit period through HAP's Contracted Providers for Pediatric Members only. Detailed information regarding coverage of lenses, Collection Frames, and Collection Contacts can be found in your policy or plan documents.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$45 Copay - Deductible does not apply	N/A	May be rendered at home.Rehabilitative Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Rehabilitative Speech Therapy up to 30 visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	$45 Copay - Deductible does not apply	N/A	Physical and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. Limits do not apply for treatment of autism.
Applied Behavioral Analysis	$35 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
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	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$5 Copay 30 day supply, $10 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	$30 Copay 30 day supply, $60 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply		
Preferred Specialty Drugs	20% Coinsurance ($200 max) 30 day supply at Specialty pharmacy only		
Non Preferred Specialty Drugs	50% Coinsurance ($500 max) 30 day supply at Specialty pharmacy only		

Template Rev 01/2020

- 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.