Senior Plus (hmo)

Health Alliance Plan of Michigan
HAP Senior Plus HMO
VEBA FORD-GENERAL - MEDICARE ADVANTAGE (MA)

MA000194 **QR-35055**

Health Care Services	In-Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	$400 Individual; $675 Family	Deductible does not apply to Laboratory and Pathology Services, Durable Medical Equipment, Prosthetics & Orthotics, and Diabetic Supplies. Emergency & Urgent care copays do not reduce the deductible.
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	None	
Maximum-Out-of-Pocket Cost**	$1,500 Individual	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing applies.
Medicare-Covered Preventive Services (partial list):		
Annual Wellness Visit	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$25 Copay - Deductible does not apply	
Telehealth	$25 Copay - Deductible does not apply	Through our contracted telehealth services provider
Specialty Physician Office Visit	$35 Copay - Deductible does not apply	
Gynecology Office Visit	$35 Copay - Deductible does not apply	
Audiology Office Visit	$35 Copay - Deductible does not apply	
Eye Examination Office Visit	$25 Copay - Deductible does not apply	
Allergy Treatment and Injections	Covered after Deductible	
Laboratory and Pathology Services	Covered - Deductible does not apply	
Radiology Services	Covered after Deductible	
Dialysis	Covered after Deductible	
Chemotherapy	Covered after Deductible	
Radiation Therapy	Covered after Deductible	
Outpatient Surgery	Covered after Deductible	
Chiropractic Services	$20 Copay - Deductible does not apply	Manipulation of the spine for subluxation only

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Emergency/Urgent Care:		
Emergency Room Services	$50 Copay -Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$25 Copay - Deductible does not apply	
Emergency Ambulance Services	Covered after Deductible	
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 after Deductible	
Bariatric Surgery & Related Services	Covered after Deductible	
Mental/Behavioral Health:		
Inpatient Services *	Covered after Deductible	Unlimited
Outpatient Services	Covered - Deductible does not apply	Unlimited
Substance Use Disorder:		
Inpatient Services *	Covered after Deductible	Unlimited
Outpatient Services	Covered - Deductible does not apply	Unlimited
Other Services:		
Home Health Care	Covered after Deductible	
Hospice Care	You must get care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not HAP Senior Plus.	
Skilled Nursing Care	Covered after Deductible	Up to 100 days per benefit period. Hospital stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	Covered - Deductible does not apply	Coverage provided for approved equipment based on Medicare guidelines.
Hearing Aid Exam / Hearing Aid	$0 Exam / $0 - $1,575 Copay per hearing aid	Exclusive benefit through NationsHearing, L.L.C. See Evidence of Coverage (EOC) for benefits relating to hearing aids.

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Vision Hardware	Covered	One pair of eyeglasses allowed every 12 months; dollar limit applies. Contact lenses in place of eyeglasses are covered, subject to a maximum retail allowance. Contact lens fitting is not covered. See Evidence of Coverage (EOC) for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	Covered after Deductible	Unlimited
Occupational Therapy (OT)	Covered after Deductible	Unlimited
Pharmacy:		
Prescription Drugs	Not Covered by HAP	For information on your Pharmacy coverage, please contact Express Scripts Medicare at 866-662-0274

Riders: S000, S030, S045, X400, X401, X405, X418, X436, X437, X438, X461, X550, X552, XNEW:$400/$675 DED,1 PER $400/2 PER $275, EXCL DME/P&O & LAB/PATH; X560, X574

* Please contact HAP if you are admitted to the hospital.
**Limit on the total of copays or co-insurance you might pay during the benefit period.
The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. In cases of conflict between this summary and your Evidence of Coverage, the terms and conditions of the Evidence of Coverage govern.
Health Alliance Plan is a health plan with a Medicare contract. Enrollment in the plan depends on contract renewal.