MA

MA MSPTA Retired On or After 10/1/87

Health Alliance Plan of Michigan
HAP Senior Plus HMO
STATE OF MICHIGAN - FULL HMO NETWORK (MAPD)

MA000150 / XS000120

QR-35174

Health Care Services	In-Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	$125 Individual	Excludes Durable Medical Equipment/Prosthethics & Orthotics, Physical/Speech/Occupational Therapy, Private Duty Nursing, Outpatient Laboratory, Pathology, Tubal Ligations, and Allergy Injections.
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	None	
Maximum-Out-of-Pocket Cost**	$500 Individual	These values do not accumulate: Premiums, balance-billed charges, Part D pharmacy liabilities, and health care this plan doesn't cover. All other cost sharing applies.
Medicare-Covered Preventive Services (partial list):		
Annual Wellness Visit	Covered	One annual physical exam per benefit period at no cost share.
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$ 20 Copay	
Telehealth	$10 Copay	Through our contracted telehealth services provider.
Specialty Physician Office Visit	$ 20 Copay	
Gynecology Office Visit	$ 20 Copay	
Routine Eye Examination Office Visit	$ 20 Copay	Through our contracted provider EyeMed only.
Medical Eye Examination Office Visit	$ 20 Copay	
Audiology Office Visit	$ 20 Copay	
Allergy Injections	Covered	
Allergy Testing and Therapy	Covered after deductible	
Diagnostic Laboratory & Pathology	Covered	
Radiology (X-ray)	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	Manipulation of the spine for subluxation only
Emergency/Urgent Care:		
Emergency Room Services	$65 Copay - Applies to the deductible	Copay will be waived if admitted
Urgent Care Facility Services	$20 Copay - Applies to the deductible	
Emergency Ambulance Services	Covered after deductible	Emergency transport only

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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	
Mental/Behavioral Health:		
Inpatient Services *	Covered after deductible	Unlimited
Outpatient Services	$20 Copay	Unlimited
Substance Use Disorder:		
Inpatient Services *	Covered after deductible	Unlimited
Outpatient Services	$20 Copay	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 120 days per confinement. Hosptial stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	Covered	Coverage provided for approved equipment based on Medicare guidelines - with Wigs
Private Duty Nursing	Covered	
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.
Vision Hardware	Not Covered	See Evidence of Coverage (EOC) for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	$20 Copay	Medicare guidelines and authorization rules apply.
Occupational Therapy (OT)	$20 Copay	Medicare guidelines and authorization rules apply.
Assisted Reproductive Technologies	Covered after deductible	One attempt of artificial insemination per lifetime
Voluntary Sterilization	Women: Covered Men: Covered after deductible	Limited to Vasectomy and Tubal Ligation
Pharmacy:		
Tier 1: Preferred Generic drugs - $10 Copay Tier 2: Generic drugs- $10 Copay Tier 3: Preferred Brand drugs- $30 Copay Tier 4: Non-Preferred Brand drugs- $60 Copay Tier 5: Specialty drugs- $60 Copay Tier 6: Select Care drugs - $0 Copay	$1,500 Out-of Pocket Maximum for Presciption Drugs	Coverage in the GAP Retail/Mail Order: 30 day supply for Part D drugs for 1 copay; 90 day supply of Part D drugs for 2 times the 30 day copay. Tier 5 and 6 drugs are only available at 30-day supply.

Riders: S000,S014,S057,S061,S134,X400,X401,X423,X462,X496,X499,X540,X558,X574,X577,X579,X595,S419

* 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 year.
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.