Health Alliance Plan of Michigan
HAP Senior Plus HMO
UAW Trust Ford General

Health Care Services	In-Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	$250 Individual; $525 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	One annual physical exam per benefit period at no cost share.
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	$ 15 Copay - Deductible does not apply	
Telehealth	$ 15 Copay - Deductible does not apply	Through our contracted telehealth services provider.
Specialty Physician Office Visit	$ 25 Copay - Deductible does not apply	
Gynecology Office Visit	$ 25 Copay - Deductible does not apply	
Routine Eye Examination Office Visit	$ 15 Copay - Deductible does not apply	Through our contracted provider EyeMed only. For non-routine visits see Specialist Physician Office Visit.
Medical Audiology Office Visit	$ 25 Copay - Deductible does not apply	For hearing aid exam, please see Hearing Aid benefit.
Allergy Treatment and Injections	Covered after Deductible	
Diagnostic Laboratory & Pathology	Covered - Deductible does not apply	
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 - Deductible does not apply	Manipulation of the spine for subluxation only.

Health Alliance Plan of Michigan
HAP Senior Plus HMO
UAW Trust Ford General

Health Care Services	In-Network Coverage	Limitations
Emergency/Urgent Care:		
Emergency Room Services	$ 50 Copay - Deductible does not apply	Copay will be waived if admitted.
Urgent Care Facility Services	$ 15 Copay - Deductible does not apply	
Emergency Ambulance Services	Covered after Deductible	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 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	Unlimited. 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.

Health Alliance Plan of Michigan
HAP Senior Plus HMO
UAW Trust Ford General

Health Care Services	In-Network Coverage	Limitations
Other Services:		
Vision Hardware	Covered	Corrective eyeglasses and/or contact lenses are covered once every 12 month period when prescribed by and purchased from an EyeMed-Participating ophthalmologist or optometrist with a $100 combined benefit maximum. See EOC for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	Covered after Deductible	Unlimited
Occupational Therapy (OT)	Covered after Deductible	Unlimited
Visitor/Traveler Benefit	In-Network coverage with a Medicare-contracted provider when traveling to Florida, Arizona, Texas and out of area Michigan for up to 12 months. See EOC for full benefit details.	
Pharmacy:		
Prescription Drugs	Not Covered	For information on your Pharmacy coverage, please contact Optum.

Effective 1/2024

* 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.