



**Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits - UAW Trust GM Protected Medicare Advantage (MA000196)**

Health Care Services	In-Network	Limitations
Plan Attributes		
Benefit Period	Calendar Year	
Annual Deductible	None	
Coinsurance (amount member pays)	None	
Annual Coinsurance Maximum	None	
Maximum Out-of-Pocket Cost**	\$1,500 Individual	These values do not accumulate: Premiums, balance-billed charges and health care this plan does not cover. All other cost-sharing applies
Medicare-Covered Preventive Services (partial list)		
Preventive Office Visit	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services		
Personal Care Physician Office Visit	\$25 Copay	
Specialty Physician Office Visit	\$25 Copay	
Gynecology Office Visit	\$25 Copay	
Audiology Office Visit	\$25 Copay	
Eye Exam Office Visit	\$25 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Services	\$20 Copay	Manipulation of the spine for subluxation only

Emergency/Urgent Care		
Emergency Room Services	\$50 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$25 Copay	
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 and Related Services	Covered	
Mental & Behavioral Health		
Inpatient Services*	Covered	Unlimited
Outpatient Services	Covered	Unlimited
Substance Use Disorder		
Inpatient Services*	Covered	Unlimited
Outpatient Services	Covered	Unlimited
Other Services		
Home Health Care	Covered	
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	Up to 100 days per benefit period. Hospital stay not required. Authorization rules apply.
Durable Medical Equipment, Prosthetics and Orthotics	Covered	Coverage provided for approved equipment based on Medicare guidelines
Hearing Aid Hardware	Covered	Covered for authorized conventional hearing aids
Vision Hardware	Covered	One pair 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 related to cataract surgery.
Physical and Speech Therapy (PT/ST)	Covered	Unlimited
Occupational Therapy (OT)	Covered	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, S013, S030, S045, X401, X405, X560, X418, X435, X436, X437, X461, XMHE

*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 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.