2024

Summary of Benefits

HAP Medicare Advantage | MSUHC HMO

January 1, 2024 - December 31, 2024

HAP MSUHC Medicare (HMO)

H2354_HMO MSUHC 2024 Summary of Benefits_M

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, www.hap.org/medicare/member-resources/forms.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **HAP MSUHC Medicare (HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **HAP MSUHC Medicare (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov/plan-compare.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov/medicare-and-you or get a copy by calling 1-800-MEDICARE
(1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **HAP MSUHC Medicare (HMO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as large print.

This document may be available in a non-English language. For additional information, call us at 1-888-658-2536 (TTY: 711).

Things to Know About HAP MSUHC Medicare (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. Eastern Time, Monday through Friday.
- If you are a member of this plan, call us at 1-800-801-1770, TTY: 711.
- If you are not a member of this plan, call us at 1-844-793-1805, TTY: 711.
- Our website: www.hap.org/medicare.

Who can join?

To join **HAP MSUHC Medicare (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Michigan: Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Cass, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lake, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Ottawa, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw and Wayne.

Which doctors, hospitals, and pharmacies can I use?

HAP MSUHC Medicare (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.hap.providerlookuponlinesearch.com/search).

Or call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- Our plan members get *all* of the benefits covered by Original Medicare. For Medicare covered benefits, you will pay less in our plan than you would in Original Medicare.
- Our plan members also get *more than what* is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- HAP MSUHC Medicare (HMO) is a Medicare health plan with a Medicare contract and a contract with the Michigan Medicaid Program.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.hap.org/medicare/member-resources/prescriptions/formulary-drug-list.
- Or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of Tier 6 "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, what stage of the benefit you have reached and any “Extra Help” you may receive. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact HAP MSUHC Medicare (HMO) (800) 801-1770 (TTY: 711) Plan for details.

SECTION II - SUMMARY OF BENEFITS	
	HAP MSUHC Medicare (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for HAP MSUHC Medicare (HMO). You must continue to pay your Medicare Part B premium.
Deductible	$0
Maximum Out-of-Pocket Responsibility	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $4,900 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS (You will have no copays for the services listed in the Benefits Chart, as long as you continue to be eligible for full Medicaid benefits.)	
Inpatient Hospital Care	Days 1-5: $325 Copay per day. Days 6-90: $0 Copay per day. May require prior authorization.
Outpatient Hospital Services	$300 Copay for per visit. May require prior authorization.
Ambulatory Surgical Center	$275 Copay per visit. May require prior authorization.
Doctor's Office Visits	Primary care physician visit: $0 Copay. Specialist visit: $35 Copay.
Preventive Care	$0 Copay per visit.
Emergency Care	$110 Copay per visit.
Urgently Needed Services	$55 Copay per visit.

<table>
<tr><td>Diagnostic Services/Labs/Imaging (include diagnostic tests and procedures, labs, diagnostic radiology, and X-rays) Costs for these services may be different if received in an outpatient surgery setting.</td><td colspan="3">$200 Copay for diagnostic radiology services (such as MRIs, CT scans).
$200 Copay for other diagnostic tests and procedures.
$0 Copay for lab services.
$60 Copay for therapeutic radiology services (such as radiation treatment for cancer).
$35 Copay for outpatient x-rays.

Some of the above services may require prior authorization.</td></tr>
<tr><td>Hearing Services</td><td colspan="3">$0 Copay per Medicare-covered hearing exam from a primary care provider.
$35 Copay per Medicare-covered hearing exam from a specialty care provider.

<u>You must use NationsHearing for the following services:</u>
$0 Copay per routine hearing exam (up to 1 every year).
$689 - $2,039 Copay per hearing aid (up to 2 hearing aids every year).</td></tr>
<tr><td>Dental Services</td><td colspan="3">$0 Copay for the following preventive dental services: 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, 1 set of bitewings per year and simple extractions.
50% Coinsurance for the following comprehensive dental services: root canals, fillings, extractions, crown repairs. See the EOC for more details on this benefit. Maximum benefit of $3,000 per calendar year for all dental services.
You must use a participating Delta Dental PPO or Premier Network provider.</td></tr>
<tr><td colspan="4">OPTIONAL DENTAL PLANS (PURCHASED SEPARATELY)</td></tr>
<tr><td>Optional Plan Name</td><td>Plan 1 – Delta 50</td><td>Plan 2 – Delta 70</td><td>Plan 3 – Delta 100</td></tr>
<tr><td colspan="4">These optional dental plans can be purchased with a HAP Medicare Advantage plan. For plans Delta 50 and Delta 70, services must be provided by a dentist in the Delta Dental Medicare Advantage PPO™ and Medicare Advantage Premier networks in Michigan, Ohio and Indiana. For Delta 100 plan, services must be provided by a Medicare Advantage PPO™ network in Michigan, Ohio or Indiana.</td></tr>
<tr><td rowspan="2">Monthly Plan Premium</td><td>If you elect this optional supplemental benefit, you will pay an additional $19.10 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.</td><td>If you elect this optional supplemental benefit, you will pay an additional $29.50 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.</td><td>If you elect this optional supplemental benefit, you will pay an additional $51.90 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.</td></tr>
<tr><td colspan="3">You must also keep paying your Medicare Part B premium and your plan monthly premium.</td></tr>
<tr><td>Deductible</td><td colspan="3">$0</td></tr>
</table>

Maximum Out-of-Pocket Responsibility	This dental plan will pay up to $1,000 maximum plan coverage limit per calendar year.	This dental plan will pay up to $1,500 maximum plan coverage limit per calendar year.	This dental plan will pay up to $2,500 maximum plan coverage limit per calendar year.
Plan Coverage	Basic services: 50% Diagnostic & preventive services: 100% Major services: 50%	Basic services: 50% Diagnostic & preventive services: 100% Major services: 70%	Basic services: 50% Diagnostic & preventive services: 100% Major services: 100%
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)			
Vision Services	Medicare covered eye exams from a PCP: $0 Copay. Medicare covered eye exams from a Specialist: $35 Copay. <u>You must use EyeMed for the following services:</u> Routine eye exam (up to 1 visit every year): $0 Copay. The plan has a $150 allowance every calendar year for contact lenses and eyeglasses (lenses and frames). A 20% discount applies for any balance over the $150 allowance.		
Mental Health Services	$0 Copay per visit.		
Skilled Nursing Facility (SNF)	Days 1-20: $0 Copay per day. Days 21-100: $203 Copay per day. May require prior authorization.		
Physical Therapy, Occupational Therapy, and Speech Therapy	$20 Copay for each Medicare-covered therapy visit. May require prior authorization.		
Ambulance	$300 Copay for Medicare-covered ambulance services. Must have prior authorization for non-emergency ambulance services.		
Medicare Part B Drugs	20% Coinsurance for Part B drugs, including chemotherapy drugs. Step therapy requirements may apply to certain Part B drugs. Insulins covered under Medicare Part B are subject to a coinsurance cap of $35 for one month’s supply of insulin with no deductible. May require prior authorization.		

PRESCRIPTION DRUG BENEFITS	
Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information. **Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	
Deductible	$0
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$7 Copay	$14 Copay	$21 Copay
Tier 2 (Generic)	$16 Copay	$32 Copay	$48 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance	50% Coinsurance	50% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$9 Copay	$18 Copay	$27 Copay
Tier 3 (Preferred Brand)	$41 Copay	$82 Copay	$123 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance	48% Coinsurance	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay

Standard Mail Order Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$9 Copay	$18 Copay	$27 Copay
Tier 2 (Generic)	$17 Copay	$34 Copay	$51 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance	50% Coinsurance	50% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay

Preferred Mail Order Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$9 Copay	$18 Copay	$0 Copay
Tier 3 (Preferred Brand)	$41 Copay	$82 Copay	$102.50 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance	48% Coinsurance	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay

You may get your drugs at Preferred or Standard network retail pharmacies and mail order pharmacies.
If you reside in a long-term care facility, you pay the same as at a Preferred retail pharmacy.
If you request and the plan approves a formulary exception, you will pay a cost-share at Tier 2 for generic drugs and at Tier 4 for brand drugs.
Costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You will pay $0 for Tier 6 (Select Care Drugs). You stay in this stage until your year-to-date **"out-of-pocket costs"** (your

	payments) reach a total of $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Amount	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay the copay or coinsurance amount listed in the plan's Drug List. These drugs are identified as "ED" in the Drug List.
ADDITIONAL COVERED BENEFITS	
Acupuncture	$0 Copay for acupuncture services for chronic low back pain from a primary care physician per visit, 20 visit limit. $35 Copay for acupuncture services for chronic low back pain from a specialist provider per visit, 20 visit limit. May require prior authorization.
Chiropractic Care	$20 Copay for each covered chiropractic services visit. • Manual manipulation of the spine to correct subluxation. • Routine care covered for one office visit per year performed by a chiropractor. $35 Copay for one set of chiropractic x-rays (up to 3 views) every year performed by a chiropractor.
Companion Care	Flex card allowance available.
Diabetes Management	20% Coinsurance per visit.
Diabetes Supplies and Services	20% Coinsurance for diabetic supplies and services.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% Coinsurance per item.
Fitness	$0 Copay for the fitness benefit. You must use SilverSneakers.
Flex Card	You have a Prepaid Benefits Mastercard with a combined annual limit of $550 a year to be used to reduce your out-of-pocket expenses to purchase dental, vision, hearing, transportation, OTC, companion care, personal emergency response systems (PERS) and healthy food items.
Foot Care *(podiatry services)*	$0 Copay for preventive podiatry services condition specific for diabetes per visit. $35 Copay for all other podiatry services per visit.
Home-Delivered Meals	Not Covered.

Home Health Agency Care	$0 Copay for home health agency care.
Hospice	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not HAP MSUHC Medicare.
Outpatient Substance Abuse	$0 Copay per visit.
Over-the-Counter Items	Flex card allowance available.
Personal Emergency Response System (PERS)	Flex card allowance available.
Prosthetic Devices *(braces, artificial limbs, etc.)*	20% Coinsurance of the cost for each Medicare-covered prosthetic device and related supply. May require prior authorization.
Renal Dialysis	20% Coinsurance for each Medicare-covered outpatient dialysis treatment.
Telehealth	$0 Copay for telehealth. You must use Amwell.
Transportation	Flex card allowance available.
Visitor/Traveler	Enjoy in-network prices for copays on routine services when you visit any Medicare-participating provider in Arizona, Florida, Michigan (out-of-service area), and Texas for up to 12 months.
Worldwide Travel Assistance	$0 Copay for worldwide travel assistance. You must use Assist America.

DISCLAIMERS

You can get this document for free in other formats, such as large print or audio. Call 1-800-848-4844 TTY 711. The call is free. April 1 through Sept. 30: Monday - Friday, 8 a.m. to 8 p.m, Oct. 1 through March 31: seven days a week, 8 a.m. to 8 p.m.

Health Alliance Plan (HAP) has HMO, HMO-POS, PPO plans with Medicare contracts. Enrollment depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat HAP Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Health Alliance Plan of Michigan.

At HAP, we're committed to helping you choose the right option for you

We're excited to show you our plan options for 2024.
Call today!

HAP Sales Agent

(844) 793-1805 (TTY: 711)

8 a.m. to 8 p.m., seven days a week (Oct. 1 – March 31)
8 a.m. to 8 p.m., Monday through Friday (April 1 – Sept. 30)

Current Members Call HAP Customer Service

(800) 801-1770 (TTY:711)

8 a.m. to 8 p.m., seven days a week (Oct. 1 – March 31)
8 a.m. to 8 p.m., Monday through Friday (April 1 – Sept. 30)

Or visit us online at **hap.org/MSUoptions.**

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MSU Health Care