Health Alliance Plan of Michigan
HAP Senior Plus (HMO-POS)- Expanded Network (MAPD)
Michigan Public Schools Employee Retirement Systems

MA000325 XS000293

Health Care Services	In-Network Coverage	Out-of-Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:			
Benefit Period:	Calendar Year		
Annual Deductible	$650 Individual	$725 Individual	Excludes diagnostic laboratory services, allergy injections, ambulance services, dialysis, chemotherapy, radiation therapy, and PTOTST.
Co-insurance (amount member pays)	10%	30%	Excludes diagnostic laboratory and radiology services, allergy injections, ambulance, home health care, chemotherapy, radiation therapy, and PTOTST.
Annual Co-insurance Maximum	N/A	N/A	
Maximum-Out-of-Pocket Cost**	$2,500 Individual	$5,000 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	30% Coinsurance after deductible	One annual physical exam per benefit period at no cost share.
Immunizations	Covered	30% Coinsurance after deductible	
Related Laboratory and Radiology Services	Covered	30% Coinsurance after deductible	
Pap Smears and Mammograms	Covered	30% Coinsurance after deductible	
Outpatient & Physician Services:			
Personal Care Physician Office Visit	Covered	30% Coinsurance after deductible	
Telehealth	Covered	Not Covered	Through our contracted telehealth services provider
Specialty Physician Office Visit	$35 Copay	30% Coinsurance after deductible	
Gynecology Office Visit	Covered	30% Coinsurance after deductible	
Audiology Office Visit	$35 Copay	Not Covered	One annual eye exam per benefit period at no cost share. Through our contracted provider EyeMed only.
Routine Eye Examination Office Visit	Covered	30% Coinsurance after deductible	
Medical Eye Examination Office Visit	$35 Copay	30% Coinsurance after deductible	
Allergy Treatment	Covered after Deductible	30% Coinsurance after deductible	
Allergy Injections	Covered	30% Coinsurance after deductible	
Diagnostic Laboratory & Pathology	Covered	30% Coinsurance after deductible	
Radiology (X-ray) Services	$10 Copay after Deductible	30% Coinsurance after deductible	In-Network copay applies per day/per provider.
High Tech Imaging	$150 Copay after Deductible	30% Coinsurance after deductible	In-Network copay applies per day/per provider.
Dialysis	10% Coinsurance	30% Coinsurance after deductible	
Chemotherapy	Covered	30% Coinsurance after deductible	
Radiation Therapy	Covered	30% Coinsurance after deductible	
Outpatient Surgery	10% Coinsurance after Deductible	30% Coinsurance after deductible	
Chiropractic Services	$10 Copay	30% Coinsurance after deductible	Manipulation of the spine for subluxation only.

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Emergency/Urgent Care:			
Emergency Room Services	$135 Copay		Copay will be waived if admitted.
Urgent Care Facility Services	$45 Copay		
Emergency Ambulance Services	$100 Copay		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	10% Coinsurance after Deductible	30% Coinsurance after deductible	
Mental/Behavioral Health:			
Inpatient Services *	10% Coinsurance after Deductible	30% Coinsurance after deductible	Unlimited
Outpatient Services	$20 Copay	30% Coinsurance after deductible	Unlimited
Substance Use Disorder:			
Inpatient Services *	10% Coinsurance after Deductible	30% Coinsurance after deductible	Unlimited
Outpatient Services	$20 Copay	30% Coinsurance after deductible	Unlimited
Other Services:			
Home Health Care	Covered after Deductible	30% Coinsurance 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	Days 1-20: Covered Days 21-100: 10% Coinsurance after Deductible	30% Coinsurance after deductible	(Combined In Network and Out of Network) Up to 100 days per benefit period. Renewable after 60 days of non-confinement. Hospital stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after Deductible	30% Coinsurance after deductible	Coverage provided for approved equipment based on Medicare guidelines
Hearing Aid Exam/ Hearing Aid	Non-Medicare covered routine hearing services: $0 hearing exam; $499 per hearing aid for Advanced Aids; $799 per hearing aid for Premium Aids	Non-Medicare covered routine hearing services with a non-NationsHearing provider are not covered.	Exclusive benefit through NationsHearing, L.L.C. See Evidence of Coverage (EOC) for benefits relating to hearing aids.
Vision Hardware	Not Covered	Not Covered	See Evidence of Coverage (EOC) for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	$10 Copay	30% Coinsurance after deductible	Covered according to Medicare guidelines. In-Network & Out-of-Network
Occupational Therapy (OT)	$10 Copay	30% Coinsurance after deductible	Covered according to Medicare guidelines. In-Network & Out-of-Network
Fitness (SilverSneakers)	Covered	Not Covered	Fitness services must be provided at SilverSneakers participating locations.
Visitor/Traveler Benefit	In-Network coverage for plan covered services with a Medicare-participating provider when traveling to all 49 states and outside of the HAP HMO Michigan Service Area for up to 12 months. See EOC for full benefit details.		
Preferred Pharmacy:	**(HAP network includes pharmacies with nationwide locations)**		
Tier 1: Preferred Generic	$8 Copay	**See EOC for certain situations**	Retail/Mail Order: 30-day supply for Part D drugs for 1 copay; 31-90 day supply of Part D drugs for 2 times the 30-day copay. Tier 5 drugs are only available at 30-day supply. Tier 1 drugs are available at 1 100-day supply @ retail and mail order.
Tier 2: Generic	$11 Copay		
Tier 3: Preferred Brand	$55 Copay		
Tier 4: Non-Preferred Drug	$85 Copay		
Tier 5: Specialty Tier	20% Coinsurance up to $120 Max per script		
Standard Pharmacy:			
Tier 1: Preferred Generic	$12 Copay		
Tier 2: Generic	$16 Copay		
Tier 3: Preferred Brand	$60 Copay		
Tier 4: Non-Preferred Drug	$90 Copay		
Tier 5: Specialty Tier	20% Coinsurance up to $120 Max per script		

Riders: SP00, XS01, XS02, XS03, X400, X551, X562, X135 X444, X471, X401, X405, X598, XS05, X550, X476, X475, X500, X587, XS568, S612

* 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.