



Health Alliance Plan of Michigan
HAP Senior Plus HMO
 Benefit Summary

Benefit Code: SSPV

Health Care Services	In-Network Coverage	Limitations *
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Lifetime Maximum	None	
Preventive Services:		
Preventive Office Visit	\$10 Copay	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	\$10 Copay	
Specialty Physician Office Visit	\$10 Copay	
Gynecology Office Visit	\$10 Copay	
Audiology Office Visit	\$10 Copay	
Eye Examination Office Visit	\$10 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	\$10 Copay	Manipulation of the spine for subluxation only



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Emergency/Urgent Care:		
Emergency Room Services	\$50 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$10 Copay	
Emergency Ambulance Services	Covered	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	
Bariatric Surgery & Related Services	Covered	One procedure per lifetime
Mental Health:		
Inpatient Services	Covered	Covered according to Medicare guidelines
Outpatient Services	\$10 Copay	Covered according to Medicare guidelines
Chemical Dependency:		
Inpatient Services	Covered	Covered according to Medicare guidelines
Outpatient Services	\$10 Copay	Covered according to Medicare guidelines
Other Services:		
Home Health Care	Covered	Does not include PT/OT/ST. See PT/OT/ST Coverage
Hospice Care	Covered	210 days lifetime
Skilled Nursing Care	Covered	Up to 730 days per benefit period
Durable Medical Equipment; Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on Medicare guidelines
Hearing Aid Hardware	Covered	Covered for authorized conventional hearing aids



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Vision Hardware	Not Covered	Following cataract surgery, 1 pair of eyeglasses or contact lenses
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	May be rendered at home
Pharmacy:		
Generic / Brand	\$5 / \$10 Copay	Retail: 35 day supply for non-maintenance drugs at one Copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 Copay Mail Order: 90 day supply of non-maintenance drugs at 3 Copays less \$5.00; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 Copay

Benefit Code / Riders: SSPV / S000,S004,S011,S013,S046,S052,S054

* Please contact HAP if you are admitted to the hospital.

In cases of conflict between this summary and your Evidence of Coverage, the terms and conditions of the Evidence of Coverage governs.