

MA000NEW / XS000NEW

Exception 67_HIGH PLAN OPTION

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	None	
Maximum-Out-of-Pocket Cost**	\$6,350 Individual	These values do not accumulate: Premiums, balance-billed charges, Part D pharmacy liabilities, and health care this plan doesn't cover. All other cost sharing applies.
Medicare-Covered Preventive Services (partial list):		
Annual Wellness Visit	Covered	One annual physical exam per benefit period at no cost share.
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	\$20 Copay	
Telehealth	Covered	Through our contracted telehealth service provider.
Specialty Physician Office Visit	\$40 Copay	
Gynecology Office Visit	\$40 Copay	
Routine Eye Examination Office Visit	Covered	One annual eye exam per benefit period at no cost share. Through our contracted provider EyeMed only.
Medical Eye Examination Office Visit	\$40 Copay	
Audiology Office Visit	\$40 Copay	
Allergy Treatment and Injections	Covered	
Diagnostic Laboratory & Pathology	Covered	
Radiology (X-ray)	Covered	
Imaging Services: MRI's CT Scans PET Scans Other imaging services	\$150 Copay per day	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	\$250 Copay	
Chiropractic Services	Covered	Manual manipulation of the spine for subluxation only.

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Emergency/Urgent Care:		
Emergency Room Services	\$125 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$50 Copay	
Emergency Ambulance Services	\$150 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	\$100 Copay per day	Maximum Copay: \$500 per admission
Mental/Behavioral Health:		
Inpatient Services *	\$100 Copay per day	Unlimited Maximum Copay: \$500 per admission
Outpatient Services	\$20 Copay	Unlimited
Substance Use Disorder:		
Inpatient Services *	\$100 Copay per day	Unlimited Maximum Copay: \$500 per admission
Outpatient Services	\$20 Copay	Unlimited
Habilitation Services		
Physical and Speech Therapy	\$40 Copay	See Evidence of Coverage (EOC) for additional benefit details.
Occupational Therapy	\$40 Copay	See Evidence of Coverage (EOC) for additional benefit details.
Applied Behavioral Analysis (ABA)	\$20 Copay	See Evidence of Coverage (EOC) for additional benefit details.
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 730 days per benefit period. Hospital stay not required. Authorization rules apply.
Durable Medical Equipment, Prosthetics & Orthotics	50% Coinsurance	Coverage provided for approved equipment based on Medicare guidelines.
Hearing Aid Exam/ Hearing Aid	\$0 Exam / \$0 - \$2,039 Copay per hearing aid	Exclusive benefit through NationsHearing, L.L.C. See Evidence of Coverage (EOC) for benefits relating to hearing aids.

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Vision Hardware	Not Covered	See Evidence of Coverage (EOC) for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	\$40 Copay	Unlimited
Occupational Therapy (OT)	\$40 Copay	Unlimited
Fertility Preservation Medically Necessary Fertility Preservation. Includes Storage for preserved specimen for 1 year after a covered preservation procedure.	\$40 Copay per visit	See Evidence of Coverage (EOC) for additional benefit details.
Assisted Reproductive Technologies	Covered	Unlimited
Temporomandibular Joint Disorder Coverage for non-invasive treatments only.	Covered	See Evidence of Coverage (EOC) for additional benefit details.
Voluntary Sterilization	Women: Covered Men: \$250 Copay per surgical session	Limited to tubal ligation and vasectomy.
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:		
Tier 1: Preferred Generic drugs- \$4 Copay Tier 2: Non-Preferred Generic drugs- \$10 Copay Tier 3: Preferred Brand drugs- \$40 Copay Tier 4: Non-Preferred Brand drugs- \$60 Copay Tier 5: Preferred Specialty drugs- \$20% Coinsurance (\$200 Maximum)	Covered	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. See EOC for additional information.

Riders: S000, XNEW: \$6350 OOP MAX, XNEW: \$20 PCP/\$40 SPEC(\$0 PREV SERVICES) OFFICE VISIT COPAY; X400, X418, X551, X562, XNEW: \$125 ER COPAY, X483, XNEW: 150 EMT COPAY, XNEW: 50% DME, X448, X461, X558, X550, XNEW: \$150 COPAY HIGH TECH (PER DAY), XNEW: \$100 IP COPAY (\$500 MAX PER ADMISSION), SNEW: HABILITATION SERVICES, SNEW: ART-UNLIMITED, SNEW:FERTILITY PRESERVATION; SNEW: TMJ (INCLUDES ORTHO), SNEW: ENHANCED NUTRITIONAL SERVICES (FEEDING OUTSIDE TUBE), XNEW:\$250 OUT PT SX COPAY, SNEW:NATIONS HEARING:CPY PR HA AID-\$0-\$2.039(0VALUE;689BASIC;989 PRIME;1539 ADVNCD;2039 PREM),SNEW:VOL STERILIZATION-WOMEN-TUBAL LIGATIONS-100% Covered. VASECTOMIES-PLAN ATTRIBUTES (INCLUDES OUT PT COPAY IF APP),X568, X549, SNEW:\$4 Preferred Generic /\$10 NON PREFERRED Generic/\$40 Preferred Brand/\$60 Non-Preferred Brand/20% PREFERRED Specialty w/\$200 max - 30 DAY(90 Days @ 2 Copays) - Part B Drugs 0%

* 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.