

MA000NEW / XS000NEW

Exception 69\_STANDARD OPTION

Health Care Services	In-Network Coverage	Limitations
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	\$350 Individual	Excludes Preventive Services, Office visits, Telehealth, Emergency Room, Urgent Care Services, Physical, Speech, and Occupational Therapy, Habilitation Services, Fertility Preservation Services, Voluntary Sterilization for tubal ligation, Skilled Nursing Care: Days 1-20, and Hearing Aid Exam/Hearing Aid.
Co-insurance (amount member pays)	10%	Excludes Preventive Services, Office visits, Telehealth, Emergency Room, Urgent Care Services, Physical, Speech, and Occupational Therapy, Habilitation Services, Fertility Preservation Services, Voluntary Sterilization for tubal ligation, Skilled Nursing Care: Days 1-20, and Hearing Aid Exam/Hearing Aid.
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.
<b>Medicare-Covered Preventive Services (partial list):</b>		
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	
<b>Outpatient &amp; Physician Services:</b>		
Personal Care Physician Office Visit	\$20 Copay	
Telehealth	Covered	Through our contracted telehealth service provider.
Specialty Physician Office Visit	\$50 Copay	
Gynecology Office Visit	\$50 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	\$50 Copay	
Audiology Office Visit	\$50 Copay	
Allergy Treatment and Injections	10% Coinsurance after Deductible	
Diagnostic Laboratory & Pathology	10% Coinsurance after Deductible	
Radiology (X-ray)	10% Coinsurance after Deductible	
Imaging Services: MRI's CT Scans PET Scans Other imaging services	10% Coinsurance after Deductible	
Dialysis	10% Coinsurance after Deductible	
Chemotherapy	10% Coinsurance after Deductible	
Radiation Therapy	10% Coinsurance after Deductible	
Outpatient Surgery	10% Coinsurance after Deductible	
Chiropractic Services	\$20 Copay	See Evidence of Coverage (EOC) for benefits relating to chiropractic services.

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<b>Emergency/Urgent Care:</b>		
Emergency Room Services	\$125 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$50 Copay	
Emergency Ambulance Services	10% Coinsurance after Deductible	Emergency transport only
<b>Inpatient Hospital Services: *</b>		
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	
<b>Mental/Behavioral Health:</b>		
Inpatient Services *	10% Coinsurance after Deductible	Unlimited
Outpatient Services	\$20 Copay	Unlimited
<b>Substance Use Disorder:</b>		
Inpatient Services *	10% Coinsurance after Deductible	Unlimited
Outpatient Services	\$20 Copay	Unlimited
<b>Habilitation Services</b>		
Physical and Speech Therapy	\$25 Copay	See Evidence of Coverage (EOC) for additional benefit details.
Occupational Therapy	\$25 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.
<b>Other Services:</b>		
Home Health Care	10% 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	\$0 Copay- Days 1-20 10% Coinsurance after Deductible- Days 21-730	Up to 730 days per benefit period. Hospital stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after Deductible	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)	\$25 Copay	Unlimited
Occupational Therapy (OT)	\$25 Copay	Unlimited
Fertility Preservation Medically Necessary Fertility Preservation. Includes Storage for preserved specimen for 1 year after a covered preservation procedure.	\$50 Copay per visit	See Evidence of Coverage (EOC) for additional benefit details.
Assisted Reproductive Technologies	10% Coinsurance after Deductible	Unlimited
Temporomandibular Joint Disorder Coverage for non-invasive treatments only.	10% Coinsurance after Deductible	See Evidence of Coverage (EOC) for additional benefit details.
Voluntary Sterilization	Women: Covered Men: 10% Coinsurance after Deductible	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.	
<b>Pharmacy:</b>		
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:\$350 DEDUCTIBLE, 10% COI (DED & COIN EXCL SNF DAYS 1-20 & Tubal Ligations, PTOTST, HABILITATION, FERTILITY PRESERVATION); XNEW: \$20 PCP/\$50 SPEC(\$0 PREV SERVICES) OV COPAY; X400, X418, X551, X562, XNEW:\$125 ER Copay, X483,X448, X461  
XNEW: 50 % DME; X559; X550; X568; XNEW: \$25 Copay PTOTST, SNEW: HABILITATION SERVICES, SNEW: ART-UNLIMITED, SNEW:FERTILITY PRESERVATION (Specialist Copay); SNEW: TMJ (INCLUDES ORTHO), SNEW: ENHANCED NUTRITIONAL SERVICES (FEEDING OUTSIDE TUBE)  
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 APPLICABLE),  
XNEW: ENHANCED CHIRO BENEFIT-INCLUDES SET OF XRAYS PER CONDITION & EXTRA SPINAL MANIPULATION  
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 10%

\* 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.