MEDICARE SOLUTIONS

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

MA000325/XS000293

Health Care Services	In-Network Coverage	POS Out-of -Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Coinsurance Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible	$550	$725	Deductible does not apply to Office Visit Copays, Allergy Injections; Laboratory Services; Dialysis; Physical and Speech Therapy; Occupational Therapy; Emergency & Urgent Care Copays.
Coinsurance (amount enrollee pays)	10%	30%	Coinsurance does not apply to Home Health Care.
Annual Coinsurance Maximum	N/A	N/A	
Maximum-Out-of-Pocket Cost **	$2,500	$5,000	These values do not accumulate: Premiums, balance-billed charges, Part D drugs, and health care this plan does not 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	$0 Copay	30% Coinsurance after Deductible	
Telehealth	Covered		Through our contracted telehealth service provider
Specialty Physician Office Visit	$35 Copay	30% Coinsurance after Deductible	
Gynecology Office Visit	$0 Copay	30% Coinsurance after Deductible	
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	$35 Copay	30% Coinsurance after Deductible	
Audiology Office Visit	$35 Copay	30% Coinsurance after Deductible	For each Medicare-covered diagnostic hearing exam.
Allergy Injections	Covered	30% Coinsurance after Deductible	
Diagnostic Laboratory	Covered - Deductible does not apply	30% Coinsurance after Deductible	
Radiology (X-ray)	$10 Copay after Deductible	30% Coinsurance after Deductible	One copay per provider per date of service.
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
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

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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 Health Alliance Plan.		
Skilled Nursing Care	Days 1-20: $0; Days 21-100: 10% coins after deductible	30% Coinsurance after Deductible	Combined INN/OON - Limited to 100 days per benefit period renewable after 60 days of non-confinement. Hosptial stay not required. Authorization rules apply.

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Durable Medical Equipment; Prosthetics & Orthotics	10% 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	
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
Enhanced Visitor/Traveler Benefit	In-Network coverage for plan covered services with a Medicare-participating provider when traveling to any of the 49 states outside of Michigan for up to 12 months. See EOC for full benefit details.		
Pharmacy:			
<u>Preferred Pharmacy</u> Tier 1: Preferred Generic - $5 Copay Tier 2: Non-Preferred Generic - $11 Copay Tier 3: Preferred Brand - $55 Copay Tier 4: Non-Preferred Brand - $85 Copay Tier 5: Specialty Drugs - 20% Coins up to $120 max per script **<u>Standard Pharmacy</u>** Tier 1: Preferred Generic - $10 Copay Tier 2: Non-Preferred Generic - $16 Copay Tier 3: Preferred Brand - $60 Copay Tier 4: Non-Preferred Brand - $90 Copay Tier 5: Specialty Drugs - 20% Coins up to $120 max per script	$750 Individual out-of-pocket maximum for Prescription Drugs	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 1 drugs are available at a 100 day supply @ retail and mail order. Tier 5 drugs are only available at 30-day supply.

* 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 period.
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.