Alliance Health and Life Insurance Company
HAP Senior Plus PPO- Passive (MAPD)
City of Detroit Post 2014

MA000NEW XS000NEW **Custom #103**

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	$650.00 Individual (Combined In-Network and Out-of-Network)		Excludes: Allergy Injections, Emergency Room, Urgent care, Home Health Care, Hearing Aids, and Physical, Occupational, and Speech Therapy.
Co-insurance (amount member pays)	20%		Excludes: Allergy Injections, Emergency Room, Urgent care, Home Health Care, Skilled Nursing Facility (Days 1-20), Hearing Aids, and Physical, Occupational, and Speech Therapy.
Annual Co-insurance Maximum	N/A	N/A	
Maximum-Out-of-Pocket Cost**	$2,000 Individual	$2,000 Individual (Combined In-Network and Out-of-Network)	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	Covered	One annual physical exam per benefit period at no cost share In-Network only.
Immunizations	Covered	Covered	
Related Laboratory and Radiology Services	Covered	Covered	
Pap Smears and Mammograms	Covered	Covered	
Outpatient & Physician Services:			**Member Pays $0 for Part B drugs**
Personal Care Physician Office Visit	$25 Copay	$25 Copay	
Telehealth	$25 Copay	Not Covered	Through our contracted telehealth service provider.
Specialty Physician Office Visit	$25 Copay	$25 Copay	
Gynecology Office Visit	$25 Copay	$25 Copay	
Audiology Office Visit	$25 Copay	$25 Copay	
Routine Eye Examination Office Visit	Covered	Not Covered	One annual eye exam per benefit period at no cost share. Through our contracted provider EyeMed only.
Medical Eye Examination Office Visit	$20 Copay	$20 Copay	
Allergy Treatment/Injections	$25 Copay	$25 Copay	
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Radiology (X-ray) Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Imaging Services •MRI's •CT Scans •PET Scans •Other imaging services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	

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Dialysis	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Chemotherapy	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Radiation Therapy	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Outpatient Surgery	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Chiropractic Services	$20 Copay	$20 Copay	Manipulation of the spine for subluxation only. Unlimited Routine visits (See EOC for more information).
Emergency/Urgent Care:			
Emergency Room Services	$65 Copay		Copay will be waived if admitted.
Urgent Care Facility Services	$25 Copay		
Emergency Ambulance Services	20% Coinsurance after Deductible		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	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Mental/Behavioral Health:			
Inpatient Services *	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Covered for 190 days per lifetime according to Medicare guidelines, then covered for 30 days renewable after 60 days.
Outpatient Services	$25 Copay	$25 Copay	Unlimited
Substance Use Disorder:			
Inpatient Services *	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited
Outpatient Services	$25 Copay	$25 Copay	Unlimited
Other Services:			
Home Health Care	Covered	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	Days 1-20: Covered after Deductible Days 21-100: 20% Coinsurance after Deductible	Days 1-20: Covered after Deductible Days 21-100: 20% Coinsurance after Deductible	(Combined In-Network and Out-of-Network) Up to 100 days per benefit period. Hosptial stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Coverage provided for approved equipment based on Medicare guidelines

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Hearing Aid Exam/ Hearing Aid	$0 Exam / $0 - $1,575 Copay per hearing aid	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)	$25 Copay	$25 Copay	Covered according to Medicare guidelines. (Combined In-Network & Out-of-Network)
Occupational Therapy (OT)	$25 Copay	$25 Copay	Covered according to Medicare guidelines. (Combined 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.		
Pharmacy:	**HAP network includes pharmacies with nationwide locations.**		
Tier 1: Preferred Generic	$10 Copay	See EOC for certain situations	**Retail**: 30 day supply for Part D drugs for 1 copay. 31-90 day supply of Part D drugs available for 3 times the 30-day copay. **Mail Order**: 30 day supply for Part D drugs for 1 copay. 31-90 day supply of Part D drugs available for 2 times the 30-day copay. Tier 5 drugs are only available at 30-day supply. Tier 1 drugs are available at 100 day supply @ retail and mail order.
Tier 2: Generic	$45 Copay		
Tier 3: Preferred Brand	50% Coinsurance ($60 minimum up to $120 maximum)		
Tier 4: Non-Preferred Drug	50% Coinsurance ($300 minimum up to $600 maximum)		
Tier 5: Specialty Tier	50% Coinsurance ($300 minimum up to $600 maximum)		

Riders:M095, XPNEW:$650 DED COMB INN/OON (Excludes: Algy Inj, ER, UC, HHC, HA, PTOTST); 20% COIN INN/OON Excl: Algy Inj, ER, UC,HHC, SNF (Days 1-20), HA,PTOTST; XPNEW: 'MAX OOP $2K INN; $2K OON (Comb IN & OON), XPNEW $25 OV;($0 Prev) INN; OON 40% ; XPNEW: $25 OV COPAY;($0 Prev); INN & OON XP400, XP418, XP422, XP552, XP423, XPNEW: $25 UC COPAY, XPNEW: $65 ER Copay; XP401, XP405, XP598, XP558, XP550, XP568; XP427; XP574; MNEW:$10 PG/$45 Gen/50% ($60min/$120max) 50% ($300min/$600max) PB ;NPB 50% ($300min/$600max); SPEC 50% ($300min/$600max)-30 DAY MAPD RX Part B Drugs 0%; Retail: 30 D for 1x copay. 31-90 for 3x copay. Mail Order: 30 D for 1 copay. 31-90 2xs copay.

* Please report hospital admissions within 48 hours at 313-664-8833 or 1-800-288-5959.

** Limit on the total of copays or co-insurance you might pay during the benefit period.

*** Inpatient deductible cumulative - i.e., medical, mental health and behavioral medicine; copay / day based on consecutive days in hospital not cumulative across separate admissions.

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.

Alliance Medicare PPO is a health plan with a Medicare contract. Enrollment in the plan depends on contract renewal.