



MA000063-XS000076

Health Care Services	In-Network Coverage	Limitations
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	\$125	Excludes Durable Medical Equipment/Prosthetics & Orthotics, Physical/Speech/Occupational Therapy, Private Duty Nursing, Outpatient Laboratory, Pathology, and Allergy Injections
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Maximum-Out-of-Pocket Cost**	\$500 Individual	These values do not accumulate: Premiums, balance-billed charges, pharmacy liabilities, and health care this plan doesn't cover. All other cost sharing applies
<b>Preventive Services:</b>		
Preventive Office Visit	Covered	
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	
Specialty Physician Office Visit	\$20 Copay	
Gynecology Office Visit	\$20 Copay	
Audiology Office Visit	\$20 Copay	
Eye Examination Office Visit	\$20 Copay	
Allergy Injections	Covered	
Allergy Testing and Therapy	Covered after deductible	
Laboratory and Pathology	Covered	
Radiology Services	Covered after deductible	
Dialysis	Covered after deductible	
Chemotherapy	Covered after deductible	
Radiation Therapy	Covered after deductible	
Outpatient Surgery	Covered after deductible	
Chiropractic Office Visit and Related Services	\$20 Copay	Manipulation of the spine for subluxation only



MA000063-XS000076

Health Care Services	In-Network Coverage	Limitations
<b>Emergency/Urgent Care:</b>		
Emergency Room Services	\$65 Copay- Applies to the deductible	Copay will be waived if admitted
Urgent Care Facility Services	\$20 Copay - Applies to the deductible	
Emergency Ambulance Services	Covered after deductible	
<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	Covered after deductible	
Bariatric Surgery & Related Services	Covered after deductible	
<b>Mental/Behavioral Health:</b>		
Inpatient Services *	Covered after deductible	Unlimited
Outpatient Services	\$20 Copay	Unlimited
<b>Substance Use Disorder:</b>		
Inpatient Services *	Covered after deductible	Unlimited
Outpatient Services	\$20 Copay	Unlimited
<b>Other Services:</b>		
Home Health Care	Covered 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	Covered after deductible	Up to 120 days per confinement
Private Duty Nursing	Covered	
Durable Medical Equipment; Prosthetics & Orthotics	Covered	Coverage provided for approved equipment based on Medicare guidelines - with Wigs
Hearing Aid Hardware	Covered after deductible	Covered for authorized conventional hearing aids



MA000063-XS000076

Health Care Services	In-Network Coverage	Limitations
Vision Hardware	Not Covered	Following cataract surgery, 1 pair of eyeglasses or contact lenses allowed
Physical, and Speech Therapy (PTST)	\$20 Copay	May be rendered at home-Medicare Limitations Apply
Occupational Therapy (OT)	\$20 Copay	May be rendered at home-Medicare Limitations Apply
Doctor Home Visits	Covered after deductible	
Assisted Reproductive Technologies	Covered after deductible	One attempt of artificial insemination per lifetime
<b>Pharmacy:</b>		
Preferred Generic - \$10 Copay Non-Preferred Generic - \$10 Copay Preferred Brand - \$30 Copay Non-Preferred Brand - \$60 Copay Specialty Tier Drugs - \$60 Copay	\$1,500 Out-of-Pocket Maximum for Prescription Drugs	Retail/Mail: 30 day supply for Part D drugs for 1 copay; 90 day supply of Part D drugs available for 2 times the 30 day Copay.

Riders: S000, S013, S014, S042, S057,S134, X401, X423, X453, X462, X543, X496, X499, X498,X540,XMHP,S419

\* 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.

Health Alliance Plan is a health plan with a Medicare contract.