



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

NEW MAXXXXXX/ NEW XSXXXXXX

HAP EGWP PPO Custom 9020 / Rx EGWP PPO Custom 9020

Health Care Services	In-Network Coverage	Out-of -Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible	\$650 Individual Combined		Excludes: Office Visits, Emergency Room Services, Urgent Care Services, Mental Health Outpatient Services, Substance Use Outpatient Services, Physical Therapy, Occupational Therapy and Speech Therapy
Co-insurance (amount enrollee pays)	20%		
Annual Co-insurance Maximum	N/A	N/A	
Maximum-Out-of-Pocket Cost **	\$2,000 Individual Combined		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 In-Network only. 'Through our contracted provider EyeMed only.
Medical Eye Examination Office Visit	\$25 Copay	\$25 Copay	
Allergy Injections	\$25 Copay	\$25 Copay	
Allergy Treatment	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Radiology (X-ray)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
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
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



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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	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited
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 Alliance Medicare PPO.		
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. Hospital stay not required. Authorization rules apply.



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Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Coverage provided for approved equipment based on Medicare guidelines
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. In-Network & Out-of-Network
Occupational Therapy (OT)	\$25 Copay	\$25 Copay	Covered according to Medicare guidelines. In-Network & Out-of-Network
Fitness (SliverSneakers)	Covered	Not Covered	Fitness services must be provided at SilverSneakers participating locations.
Visitor/Traveler Benefit	In-Network coverage with a Medicare-contracted provider when traveling to all 49 states outside of Michigan 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.
Tier 2: Generic	\$10 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 3: Preferred Brand	\$45 Copay		
Tier 4: Non-Preferred Drug	50% Coinsurance (\$60 minimum up to \$120 maximum)		Tier 5 drugs are only available at 30-day supply.
Tier 5: Specialty Tier	50% Coinsurance (\$300 minimum up to \$600 maximum)		Tier 1 drugs are available at 100 day supply @ retail and mail order.

Riders: M095, [XP438](#) , [XP497](#) , [XP417](#) , XP421, XP418, XP422, XP552, XP423, [XP436](#) , [XP531](#) , XP401, XP405, XP598, XP558, XP550, XP568, XP427, XP574, [M676](#)

* 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.