2024

Summary of Benefits

HAP Medicare Advantage | PPO Plans

January 1, 2024 - December 31, 2024

HAP Senior Plus (PPO)

HAP Medicare Explore (PPO)

Michigan's home for health insurance

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the **"Evidence of Coverage"**. You can also see the Evidence of Coverage on our website, www.hap.org/medicare/member-resources/forms.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **HAP Senior Plus (PPO)** and **HAP Medicare Explore (PPO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **HAP Senior Plus (PPO)** and **HAP Medicare Explore (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov/plan-compare.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov/medicare-and-you or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **HAP Senior Plus (PPO)** and **HAP Medicare Explore (PPO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as large print.

This document may be available in a non-English language. For additional information, call us at 1-888-658-2536 (TTY: 711).

Things to Know About HAP Senior Plus (PPO) and HAP Medicare Explore (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-658-2536, TTY: 711.
- If you are not a member of this plan, call us at 1-844-791-0811, TTY: 711.
- Our website: www.hap.org/medicare.

Who can join?

To join **HAP Senior Plus (PPO) and HAP Medicare Explore (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for **HAP Senior Plus (PPO)** includes the following counties in Michigan: Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Newaygo, Oakland, Oceana, Osceola, Ottawa, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw and Wayne.
The service area for **HAP Medicare Explore (PPO)** includes the following counties in Michigan: Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Newaygo, Oakland, Oceana, Osceola, Ottawa, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw and Wayne.

Which doctors, hospitals, and pharmacies can I use?

HAP Senior Plus (PPO) and **HAP Medicare Explore (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.hap.providerlookuponlinesearch.com/search).

Or call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.hap.org/medicare/member-resources/prescriptions/formulary-drug-list.
- Or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact

HAP Senior Plus (PPO)

HAP Medicare Explore (PPO)

2 SECTION II - SUMMARY OF BENEFITS

	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly Plan Premium	$165 per month. In addition, you must keep paying your Medicare Part B premiums.	You do not pay a separate monthly plan premium for HAP Medicare Explore (PPO). You must continue to pay your Medicare Part B premium.
Deductible	$0	$0
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $4,000 for services you receive from in-network providers. • $4,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $5,200 for services you receive from in-network providers. • $5,200 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital	**In-Network:** Days 1-5: $250 Copay per day. Days 6-90: $0 Copay per day. May require prior authorization. **Out-of-Network:** 25% Coinsurance per stay.	**In-Network:** Days 1-5: $350 Copay per day. Days 6-90: $0 Copay per day. May require prior authorization. **Out-of-Network:** 40% Coinsurance per stay.
Outpatient Hospital	**In-Network:**	**In-Network:**

	$200 Copay per visit. May require prior authorization. **Out-of-Network:** 25% Coinsurance per visit. May require prior authorization.	$325 Copay per visit. May require prior authorization. **Out-of-Network:** 40% Coinsurance per visit. May require prior authorization.
Ambulatory Surgical Center	**In-Network:** $180 Copay per visit. May require prior authorization. **Out-of-Network:** 25% Coinsurance per visit. May require prior authorization.	**In-Network:** $275 Copay per visit. May require prior authorization. **Out-of-Network:** 40% Coinsurance per visit. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay per visit. Specialist visit: $25 Copay per visit. **Out-of-Network:** Primary care physician visit: 25% Coinsurance per visit. Specialist visit: 25% Coinsurance per visit.	**In-Network:** Primary care physician visit: $0 Copay per visit. Specialist visit: $45 Copay per visit. **Out-of-Network:** Primary care physician visit: 40% Coinsurance per visit. Specialist visit: 40% Coinsurance per visit.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $0 Copay per visit. **Out-of-Network:** 40% Coinsurance per visit.
Emergency Care	**In-Network:** $90 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $110 Copay per visit. **Out-of-Network:** 40% Coinsurance per visit.
Urgently Needed Services	**In-Network:** $55 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $55 Copay per visit. **Out-of-Network:** 40% Coinsurance per visit.

Diagnostic Services/Labs/Imaging (include diagnostic tests and procedures, labs, diagnostic radiology, and X-rays) ***Costs for these services may be different if received in an outpatient surgery setting.***	**In-Network:** Diagnostic Radiology Services (such as MRI, CAT Scan): $150 Copay Other diagnostic tests and procedures: $150 Copay. Lab services: $0 Copay Therapeutic radiology services (such as radiation treatment for cancer): $40 Copay. Outpatient X-rays: $35 Copay. Some of the above services may require prior authorization. **Out-of-Network:** Diagnostic Radiology Services (such as MRI, CAT Scan): 25% Coinsurance. Other diagnostic tests and procedures: 25% Coinsurance. Lab services: 25% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 25% Coinsurance. Outpatient X-rays: 25% Coinsurance. Some of the above services may require prior authorization.	**In-Network:** Diagnostic Radiology Services (such as MRI, CAT Scan): $270 Copay Other diagnostic tests and procedures: $180 Copay. Lab services: $0 Copay Therapeutic radiology services (such as radiation treatment for cancer): $25 Copay. Outpatient X-rays: $35 Copay. Some of the above services may require prior authorization. **Out-of-Network:** Diagnostic Radiology Services (such as MRI, CAT Scan): 40% Coinsurance. Other diagnostic tests and procedures: 40% Coinsurance. Lab services: 40% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 40% Coinsurance. Outpatient X-rays: 40% Coinsurance. Some of the above services may require prior authorization.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues when provided by a Primary Care Physician: $0 Copay Exam to diagnose and treat hearing and balance issues when provided by a Specialist Care Provider: $25 Copay You must use NationsHearing for the following services: Routine hearing exam (for up to 1 every year): $0 Copay.	**In-Network:** Exam to diagnose and treat hearing and balance issues when provided by a Primary Care Physician: $0 Copay Exam to diagnose and treat hearing and balance issues when provided by a Specialist Care Provider: $45 Copay You must use NationsHearing for the following services: Routine hearing exam (for up to 1 every year): $0 Copay.

	Hearing Aid (up to 2 hearing aids every year): $689 - $2,039 Copay. **Out-of-Network:** 25% for a Medicare-covered hearing exam from a primary care provider. 25% for a Medicare-covered hearing exam from a specialty care provider. If you receive additional services, cost sharing for those services may apply.		Hearing Aid (up to 2 hearing aids every year): $689 - $2,039 Copay. **Out-of-Network:** 40% for a Medicare-covered hearing exam from a primary care provider. 40% for a Medicare-covered hearing exam from a specialty care provider. If you receive additional services, cost sharing for those services may apply.
Dental Services	$0 Copay for the following preventive dental services: 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, 1 set of bitewings per year and simple extractions. 50% Coinsurance for the following comprehensive dental services: root canals, fillings, extractions, crown repairs. See the EOC for more details on this benefit. Maximum benefit of $3,000 per calendar year for all dental services. You must use a participating Delta Dental PPO or Premier Network provider.		$0 Copay for the following preventive dental services: 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, 1 set of bitewings per year and simple extractions. 50% Coinsurance for the following comprehensive dental services: root canals, fillings, extractions, crown repairs. See the EOC for more details on this benefit. Maximum benefit of $3,000 per calendar year for all dental services. You must use a participating Delta Dental PPO or Premier Network provider.
OPTIONAL DENTAL PLANS (PURCHASED SEPARATELY)			
Optional Plan Name	Plan 1 – Delta 50	Plan 2 – Delta 70	Plan 3 – Delta 100
These optional dental plans can be purchased with a HAP Medicare Advantage plan. For plans Delta 50 and Delta 70, services must be provided by a dentist in the Delta Dental Medicare Advantage PPO™ and Medicare Advantage Premier networks in Michigan, Ohio and Indiana. For Delta 100 plan, services must be provided by a Medicare Advantage PPO™ network in Michigan, Ohio or Indiana.			
Monthly Plan Premium	If you elect this optional supplemental benefit, you will pay an additional $19.10 per month.	If you elect this optional supplemental benefit, you will pay an additional $29.50 per month.	If you elect this optional supplemental benefit, you will pay an additional $51.90 per month.
Deductible	$0		

Maximum Out-of-Pocket Responsibility	This dental plan will pay up to $1,000 maximum plan coverage limit per calendar year.	This dental plan will pay up to $1,500 maximum plan coverage limit per calendar year.	This dental plan will pay up to $2,500 maximum plan coverage limit per calendar year.
Plan Coverage	Basic services: 50% Diagnostic & preventive services: 100% Major services: 50%	Basic services: 50% Diagnostic & preventive services: 100% Major services: 70%	Basic services: 50% Diagnostic & preventive services: 100% Major services: 100%
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)			
Vision Services	**In-Network:** Medicare covered eye exams from a PCP: $0 Copay. Medicare covered eye exams from a Specialist: $25 Copay. You must use EyeMed for the following services: Routine eye exam (up to 1 visit every year): $0 Copay. The plan has a $150 allowance every calendar year for contact lenses and eyeglasses (lenses and frames). A 20% discount applies for any balance over the $150 allowance. **Out-of-Network:** 25% for Medicare-covered standard eye wear after cataract surgery. 25% for Medicare-covered eye exams by a primary care physician. 25% for Medicare-covered eye exams by a specialty care physician. Routine eye exams and eyewear are not covered out-of-network. You must use an EyeMed provider.	**In-Network:** Medicare covered eye exams from a PCP: $0 Copay. Medicare covered eye exams from a Specialist: $45 Copay. You must use EyeMed for the following services: Routine eye exam (up to 1 visit every year): $0 Copay. The plan has a $150 allowance every calendar year for contact lenses and eyeglasses (lenses and frames). A 20% discount applies for any balance over the $150 allowance. **Out-of-Network:** 40% for Medicare-covered standard eye wear after cataract surgery. 40% for Medicare-covered eye exams by a primary care physician. 40% for Medicare-covered eye exams by a specialty care physician. Routine eye exams and eyewear are not covered out-of-network. You must use an EyeMed provider.	
Mental Health Services	**In-Network:**	**In-Network:**	

	$0 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	$0 Copay per visit. **Out-of-Network:** 40% Coinsurance per visit.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $203 Copay per day. May require prior authorization. **Out-of-Network:** 25% Coinsurance per stay.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $203 Copay per day. May require prior authorization. **Out-of-Network:** 40% Coinsurance per stay.
Physical Therapy, Occupational Therapy, and Speech Therapy	**In-Network:** $15 Copay for each Medicare-covered therapy visit. May require prior authorization. **Out-of-Network:** 25% Coinsurance for each Medicare-covered therapy visit. May require prior authorization.	**In-Network:** $20 Copay for each Medicare-covered therapy visit. May require prior authorization. **Out-of-Network:** 40% Coinsurance for each Medicare-covered therapy visit. May require prior authorization.
Ambulance	**In-Network:** $250 Copay for Medicare-covered ambulance services. Must have prior authorization for non-emergency ambulance services. **Out-of-Network:** 25% Coinsurance for Medicare-covered ambulance services. Must have prior authorization for non-emergency ambulance services.	**In-Network:** $300 Copay for Medicare-covered ambulance services. Must have prior authorization for non-emergency ambulance services. **Out-of-Network:** 40% Coinsurance for Medicare-covered ambulance services. Must have prior authorization for non-emergency ambulance services.
Medicare Part B Drugs	**In-Network:** 20% Coinsurance for Part B drugs, including chemotherapy drugs. Step therapy requirements may apply to certain Part B drugs. Insulins covered under Medicare Part B are subject to a	**In-Network:** 20% Coinsurance for Part B drugs, including chemotherapy drugs. Step therapy requirements may apply to certain Part B drugs. Insulins covered under Medicare Part B are subject to a

<table>
<tr><td></td><td>coinsurance cap of $35 for one month’s supply of insulin with no deductible.
May require prior authorization.
<u>Out-of-Network:</u>
For Part B drugs such as chemotherapy drugs: 25% Coinsurance.
May require prior authorization.</td><td>coinsurance cap of $35 for one month’s supply of insulin with no deductible.
May require prior authorization.
<u>Out-of-Network:</u>
For Part B drugs such as chemotherapy drugs: 40% Coinsurance.
May require prior authorization.</td></tr>
<tr><td colspan="3">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>$0</td><td>$0</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
<table><tr><th colspan="2">Standard Retail Cost-Sharing</th></tr><tr><th>Tier</th><th>One-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$9 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$17 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>50% Coinsurance</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 Copay</td></tr></table><table><tr><th>Tier</th><th>Two-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$18 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$34 Copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$94 Copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>50% Coinsurance</td></tr></table></td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
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</table>

Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$27 Copay
Tier 2 (Generic)	$51 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Preferred Retail Cost-Sharing	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$11 Copay
Tier 3 (Preferred Brand)	$41 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$22 Copay

Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$27 Copay
Tier 2 (Generic)	$51 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Preferred Retail Cost-Sharing	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$11 Copay
Tier 3 (Preferred Brand)	$41 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$22 Copay

Tier 3 (Preferred Brand)	$82 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$33 Copay
Tier 3 (Preferred Brand)	$123 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Standard Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$9 Copay
Tier 2 (Generic)	$17 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance
Tier 6 (Select Care Drugs)	$0 Copay

Tier 3 (Preferred Brand)	$82 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$33 Copay
Tier 3 (Preferred Brand)	$123 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Standard Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$9 Copay
Tier 2 (Generic)	$17 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$18 Copay
Tier 2 (Generic)	$34 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$18 Copay
Tier 2 (Generic)	$34 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$27 Copay
Tier 2 (Generic)	$51 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$27 Copay
Tier 2 (Generic)	$51 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	50% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Preferred Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$11 Copay
Tier 3 (Preferred Brand)	$41 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance

Preferred Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$11 Copay
Tier 3 (Preferred Brand)	$41 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance

Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$22 Copay
Tier 3 (Preferred Brand)	$82 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$0 Copay
Tier 3 (Preferred Brand)	$102.50 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.hap.org/medicare/member-resources/forms) for complete

Tier 6 (Select Care Drugs)	$0 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$22 Copay
Tier 3 (Preferred Brand)	$82 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$0 Copay
Tier 3 (Preferred Brand)	$102.50 Copay
Tier 4 (Non-Preferred Drug)	48% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 Copay

Costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.hap.org/medicare/member-resources/forms) for complete

	information about your costs for covered drugs.	information about your costs for covered drugs.
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. **Our plan covers Tier 6 Preferred Generics in the coverage gap.**	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. **Our plan covers Tier 6 Preferred Generics in the coverage gap.**
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $8,000, you pay: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay the copay or coinsurance amount listed in the plan's Drug List. These drugs are identified as "ED" in the Drug List.	After your yearly out-of-pocket drug costs reach $8,000, you pay: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay the copay or coinsurance amount listed in the plan's Drug List. These drugs are identified as "ED" in the Drug List.
ADDITIONAL COVERED BENEFITS		
Acupuncture	**In-Network:** $0 Copay for acupuncture services for chronic low back pain from a primary care physician per visit, 20 visit limit. $25 Copay for acupuncture services for chronic low back pain from a specialist provider per visit, 20 visit limit. May require prior authorization.	**In-Network:** $0 Copay for acupuncture services for chronic low back pain from a primary care physician per visit, 20 visit limit. $45 Copay for acupuncture services for chronic low back pain from a specialist provider per visit, 20 visit limit. May require prior authorization.

	Out-of-Network: 25% Coinsurance per visit.	**Out-of-Network:** 40% Coinsurance per visit.
Chiropractic Care	**In-Network:** $20 Copay for each covered chiropractic services visit. • Manual manipulation of the spine to correct subluxation. • Routine care covered for one office visit per year performed by a chiropractor. $35 Copay for one set of chiropractic x-rays (up to 3 views) every year performed by a chiropractor. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $20 Copay for each covered chiropractic services visit. • Manual manipulation of the spine to correct subluxation. • Routine care covered for one office visit per year performed by a chiropractor. $35 Copay for one set of chiropractic x-rays (up to 3 views) every year performed by a chiropractor. **Out-of-Network:** 40% Coinsurance per visit.
Companion Care	$0 Copay for up to 8 hours a month of companion care for eligible members. You must use Papa.	Not Covered.
Diabetes Management	**In-Network:** $0 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $0 Copay per visit. **Out-of-Network:** 40% Coinsurance per visit.
Diabetes Supplies and Services	**In-Network:** $0 Copay for diabetic supplies and services. **Out-of-Network:** 25% Coinsurance for diabetic supplies and services.	**In-Network:** $0 Copay for diabetic supplies and services. **Out-of-Network:** 40% Coinsurance for diabetic supplies and services.
Durable Medical Equipment ***(wheelchairs, oxygen, etc.)***	**In-Network:** 20% Coinsurance per item. **Out-of-Network:** 25% Coinsurance per item.	**In-Network:** 20% Coinsurance per item. **Out-of-Network:** 40% Coinsurance per item.
Fitness	$0 Copay for the fitness benefit. You must use SilverSneakers.	$0 Copay for the fitness benefit. You must use SilverSneakers.
Flex Card	Not Covered.	Not Covered.

Foot Care *(podiatry services)*	**<u>In-Network:</u>** $0 Copay for preventive podiatry services condition specific for diabetes per visit. $25 Copay for all other podiatry services per visit. **<u>Out-of-Network:</u>** 25% Coinsurance per visit.	**<u>In-Network:</u>** $0 Copay for preventive podiatry services condition specific for diabetes per visit. $45 Copay for all other podiatry services per visit. **<u>Out-of-Network:</u>** 40% Coinsurance per visit.
Home-Delivered Meals	$0 Copay for 28 home-delivered meals/14 days upon discharge after a hospital admission. Limited to two discharges.	Not Covered.
Home Health Agency Care	**<u>In-Network:</u>** $0 Copay for home health agency care. **<u>Out-of-Network:</u>** 25% Coinsurance per visit.	**<u>In-Network:</u>** $0 Copay for home health agency care. **<u>Out-of-Network:</u>** 40% Coinsurance per visit.
Hospice	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not HAP Senior Plus.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not HAP Medicare Explore.
Outpatient Substance Abuse	**<u>In-Network:</u>** $0 Copay per visit. **<u>Out-of-Network:</u>** 25% Coinsurance per visit.	**<u>In-Network:</u>** $0 Copay per visit. **<u>Out-of-Network:</u>** 40% Coinsurance per visit.
Over-the-Counter Items	$100 allowance per quarter through your medical benefit. Unused quarterly benefits will roll over to the next quarter and must be used by the end of the plan year. You must use NationsOTC.	$70 allowance per quarter through your medical benefit. Unused quarterly benefits will roll over to the next quarter and must be used by the end of the plan year. You must use NationsOTC.
PERS (Personal Emergency Response System)	$0 Copay for personal emergency response system for those who qualify. You must use NationsResponse.	Not Covered.

Prosthetic Devices ***(braces, artificial limbs, etc.)***	**In-Network:** 20% Coinsurance of the cost for each Medicare-covered prosthetic device and related supply. May require prior authorization. **Out-of-Network:** 25% Coinsurance per item.	**In-Network:** 20% Coinsurance of the cost for each Medicare-covered prosthetic device and related supply. May require prior authorization. **Out-of-Network:** 40% Coinsurance per item.
Renal Dialysis	**In-Network:** 20% Coinsurance for each Medicare-covered outpatient dialysis treatment. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** 20% Coinsurance for each Medicare-covered outpatient dialysis treatment. **Out-of-Network:** 40% Coinsurance per visit.
Telehealth	$0 Copay for telehealth. You must use Amwell.	$0 Copay for telehealth. You must use Amwell.
Transportation	$0 Copay/12 one-way trips. Please contact Customer Service for information on how to arrange transportation.	Not Covered.
Visitor/Traveler	Enjoy in-network prices for copays on routine services when you visit any Medicare-participating provider while traveling to any of the 49 states outside of Michigan for up to 12 months.	Enjoy in-network prices for copays on routine services when you visit any Medicare-participating provider while traveling to any of the 49 states outside of Michigan for up to 12 months.
Worldwide Travel Assistance	$0 Copay for worldwide travel assistance. You must use Assist America.	$0 Copay for worldwide travel assistance. You must use Assist America.

DISCLAIMERS

You can get this document for free in other formats, such as large print or audio. Call 1-800-848-4844 TTY 711. The call is free. April 1 through Sept. 30: Monday - Friday, 8 a.m. to 8 p.m, Oct. 1 through March 31: seven days a week, 8 a.m. to 8 p.m.

Health Alliance Plan (HAP) has HMO, HMO-POS, PPO plans with Medicare contracts. Enrollment depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat HAP Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Health Alliance Plan of Michigan.

At HAP, we're committed to helping you choose the right option for you

We're excited to show you our plan options for 2024.
Call today!

HAP Sales Agent

(844) 791-0811 (TTY: 711)

8 a.m. to 8 p.m., seven days a week (Oct. 1 – March 31)
8 a.m. to 8 p.m., Monday through Friday (April 1 – Sept. 30)

Current Members Call HAP Customer Service

(888) 658-2536 (TTY:711)

8 a.m. to 8 p.m., seven days a week (Oct. 1 – March 31)
8 a.m. to 8 p.m., Monday through Friday (April 1 – Sept. 30)

Or visit us online at **hap.org/ppoplans.**

Health Alliance Plan | 1414 E. Maple Rd. | Troy, MI 48083

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