Facts about your EPO plan

HAP EPO plans make it easier for you to get and stay healthy

What does EPO stand for:

An EPO, or exclusive provider organization, is a health plan similar to a PPO.

- EPO members have access to Health Alliance Plan's affiliated physicians through our statewide PPO network.
- EPO members do not need to select a primary care physician (PCP) and referrals are NOT required to see a specialist.
- If you have an emergency or urgent care need, your services are covered 24/7, at any emergency or urgent care facility worldwide.

As an EPO enrollee:

- EPO members obtain all preventive, routine and specialty care services from in-network providers. With the exception of emergency and urgent care services, there is no coverage if you seek services from non-network providers.
- EPO members have access to our national pharmacy network and Students Away program.
- If you have an EPO group plan, you can seek care through our statewide PPO network in Michigan and northwest Ohio. If you permanently reside outside of Michigan, your employer will enroll you in an out-of-area subgroup, where you will get care through Aetna Signature Administrators national PPO network.
- HAP has partnered with Aetna Signature Administrators® for members permanently living outside of Michigan. The Aetna network gives you access to more than 1.4 million providers including over 6,100 hospitals and thousands of MinuteClinic® locations around the country.
- You are covered for a wide range of routine services including annual wellness checkups, breast cancer screenings, immunizations and more. For a full list of preventive services, visit **hap.org/preventive-services.**

-continued

HAP720501 - 7/2025

We want to help you achieve the best health possible. We offer many health and wellness programs:

- Care management programs
- iStrive personalized digital wellness tools
- Behavioral health resources
- Weight management
- Tobacco cessation support

Learn more at **hap.org/health**

When you're a HAP member, you can access:

- Your online member account at **hap.org/login**
- Telehealth services at **hap.org/telehealth**
- Health Care Cost Estimator at **hap.org/hap-member/costestimator**
- HAP Member Discounts at **hap.org/member-discounts**
- A dedicated team to answer your questions by calling **(800) 422-4641 (TTY: 711)**

Learn more at **hap.org/through-employer/member-resources.**

Benefit Explainer Summaries

Behavioral Health

HAP's Coordinated Behavioral Health Management team can connect members to specialists to help with mental illness and addictions.

hap.org/cbhm

Diabetes Care

HAP members diagnosed with type 1 and type 2 diabetes can receive disease management support so they may better manage their condition.

hap.org/diabetescare

Health Care Cost Estimator

Our Health Care Cost Estimator is an online tool designed to provide you with estimated prices for doctor visits, procedures, and treatments.

hap.org/cost

Member Discounts

Exclusive discounts on a variety of health and wellness-related activities and services, helping HAP members stay healthy while saving money.

hap.org/discounts

Students Away – Coverage for Dependents

Healthcare coverage for full-time students aged 17 through 25 as part of an employer-provided plan.

hap.org/students

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

HAP658800 – 5/2025

Health Programs and Vendor Summaries

Fitness Programs

Active&Fit® Discount Gym Membership and Fitness

The Active&Fit fitness benefit offers HAP commercial members a discount on popular gym memberships in Michigan, including digital workout videos and one-on-one well-being coaching, for a low monthly fee.

hap.org/fitness

SilverSneakers® Fitness Benefit

The SilverSneakers fitness program is designed to promote an active and healthy lifestyle for Medicare Advantage seniors. SilverSneakers provides local and nationwide access to gyms, 24/7 online classes, and virtual trainers.

hap.org/fitness

Pharmacy Programs

Prescription Drug Home Delivery

HAP members can have prescription medications mailed right to their door with free home-delivery pharmacy service through Pharmacy Advantage.

hap.org/delivery

Continued

HAP658810 – 5/2025

Prevention Focused Programs

Assist America – Travel & ID Theft Protection

HAP members receive Emergency Travel Protection assistance when travelling over 100 miles from home, and Identify Theft Protection.

hap.org/assist

Vision Coverage

The HAP vision benefit through EyeMed provides a free annual routine eye exam, plus access to 6,000+ providers in Michigan, and discounts on name brand frames and contact lenses.

hap.org/myvision

Telehealth Benefits

Licensed and board-certified doctors are available 24/7 for live, online visits via mobile phone, tablet, or computer. Ideal for non-emergency illnesses.

hap.org/telehealth

Henry Ford Health Virtual Care

HAP members can engage with a Henry Ford doctor any time, any place — via video visits, email, and messaging. Members have 24/7 access to non-emergency medical advice and in-home remote monitoring for chronic conditions.

hap.org/telehealth

Supportive Care Programs

Maternity Services

Fully integrated program helps HAP members through each step of their pregnancy journey with interventions via mobile app, remote patient monitoring and case management. End to end engagement for all risk levels – fertility, pregnancy, postpartum, parenting, and return to work.

hap.org/mymaternity

Alliance Health and Life Insurance Company
Enrollment Application

To be filled out by employer			
Group ID	Sub-Group ID	Class ID	Effective Date of Coverage

NOTE: Orange shaded areas are required.

To be filled out by the applicant

Enrolling for ☐ EPO ☐ PPO ☐ Aetna

Last Name	Legal First Name	Middle Initial	Primary Phone	Birth Date	☐ Male ☐ Female	Race/ Ethnicity (see codes below)	Social Security Number
						__/__	

Address	Apt	City	State	Zip	County	Tobacco Use (over last six months)** ☐ Yes ☐ No	Email

Name of Employer	Date of Hire (required)	Location Code	Date of Retirement (if applicable)

IMPORTANT: ***List family members you are covering. Legal first name and middle initial only. Last name if different from yours.***

Name and Middle Initial of Dependents	Social Security Number	Birth Date*	Sex	Race/ Ethnicity (see codes below)	Tobacco Use (over last six months)**	Relation-ship (see codes below)
				__/__	☐ Yes ☐ No	
				__/__	☐ Yes ☐ No	
				__/__	☐ Yes ☐ No	
				__/__	☐ Yes ☐ No	
				__/__	☐ Yes ☐ No	

*A permanently disabled child of the Applicant (or Applicant's Spouse) can be enrolled even if over the age of 26. However, the permanently disabled child over the age of 26 cannot be married, must have been permanently disabled before reaching the age of 26 and must rely upon the Applicant (or Applicant's Spouse) for more than half of their support. We require proof of permanent disability within 31 days of enrollment.

**Applies to any applicant over age 18 who uses tobacco products regularly (four or more times per week), excluding those for religious use.

Race		Ethnicity	Relationship Codes
00 Unknown	**11** Vietnamese	**00** Unknown	**M** Subscriber
01 Decline to Report	**12** Other Asian	**01** Decline to Report	**H** Husband/Spouse
02 White	**13** Native Hawaiian or Other Pacific Islander	**20** Hispanic	**W** Wife/Spouse
03 Black or African American		**21** Not Hispanic	**DP** Domestic Partner
04 American Indian or Alaska Native	**14** Native Hawaiian	**22** Cuban	**S** Son (Dependent)
05 Asian	**15** Guamanian or Chamorro	**23** Mexican, Mexican American, Chicano/a	**D** Daughter (Dependent)
06 Asian Indian	**16** Samoan	**24** Puerto Rican	**OP** Other Partner (University Clients Only)
07 Chinese	**17** Other Pacific Islander	**25** An Ethnicity Not Listed Above	**HD** Permanently Disabled (Dependent)
08 Filipino	**18** Middle Eastern or North African		**SD** Sponsored Dependent (without Medicare)
09 Japanese	**19** Another Race Not Listed Above		**SR** Senior Rider (with Medicare)

Continued on back

To be filled out by the applicant		
Does anyone listed above have other health care coverage? If yes, complete the following: ☐ Self ☐ Spouse ☐ Dependent Type of coverage: ☐ BCBS ☐ Other _____ Medicare Number _____ Effective Date for Part A _____ Effective Date for Part B _____ Medicaid Number _____	**Have you or any of your dependents previously been a HAP or Alliance member?** ☐ Yes ☐ No Name _____ Former Number _____ Name/# _____ Name/# _____ Name/# _____	**Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMSCO)?** ☐ Yes ☐ No If yes, please attach document. **Does a qualified medical child support order (QMSCO) exist for any dependent child(ren) listed on this application?** ☐ Yes ☐ No If yes, please attach document.

Must be signed below by person applying for coverage.

I am applying for the group health benefits that I am eligible for with my employer. All of the information I have given in this application is true and complete.

I know that if I give any false or misleading information on purpose my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that if I leave out important information on this form my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that I must also give true and complete information for my dependents (such as children, spouse or partner) or their enrollment may be rejected or terminated back to the date of the application.

Applicant Signature Date MM/DD/YY

Nondiscrimination Notice

Health Alliance Plan of Michigan (HAP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. HAP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HAP provides:

- **Free aids and services to help people communicate effectively with us**
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, others)
- **Free language services to people whose primary language is not English**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact HAP's customer service manager:

General - (800) 422-4641 (TTY: 711) **Medicare -** (800) 801-1770 (TTY: 711)

Hours are 8 a.m. to 8 p.m., Seven Days a Week (Oct. 1 – March 31) and
8 a.m. to 8 p.m., Monday through Friday (April 1 - Sept. 30)

If you believe that HAP has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability or sex, you can file a grievance with HAP's Appeal & Grievance team. Use the information below:

- **Mail:** 1414 E. Maple Rd., Troy, Michigan 48083
- **Phone:** **General -** (800) 422-4641 (TTY: 711)
  Medicare - (800) 801-1770 (TTY: 711)
- **Fax:** (313) 664-5866

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** Use the Office for Civil Rights' Complaint Portal Assistant at: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.
- **Phone:** (800) 368-1019 or TTY: (800) 537-7697.

Complaint forms are also available at **www.hhs.gov/ocr/filing-with-ocr/**

Notice of Availability of Language Assistance Services and Auxiliary Aids

ENGLISH:
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-801-1770 (TTY:711) or speak to your provider.

SPANISH:
ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-801-1770 (TTY: 711) o hable con su proveedor.

ARABIC:
انتباه: إذا كنت تتحدَّث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفِر أيضًا المساعدات وخدمات المساعدة مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم الآتي: 1-800-801-1770 (الهاتف النصي: 711) أو تحدَّث إلى مقدِم الخدمة.

CHINESE TRADITIONAL:
請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電 1-800-801-1770 (TTY: 711)或聯絡您的提供者。

CHINESE SIMPLIFIED:
请注意：如果您说中文，您可以免费获得语言协助服务。另免费提供适当的辅助工具和服务并以无障碍格式提供信息。请致电 1-800-801-1770 (TTY: 711)或联系您的提供者。

ARAMAIC:
ܙܘܗ̈ܪܐ: ܐܢ ܗܡܙܡܬ ܡܢܕܝ ܒܠܫܢܐ ܐܬܘܪܝܐ، ܡܫܡܫܢ̈ܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܒܕ ܗܘܝ ܦܬܝܚ̈ܐ ܥܠ ܡܓܢ̈ܝܘܬܐ ܕܥܘܕܪ̈ܢܐ
ܠܘܬܟ ܒܡܓܢܐ. ܐܦ ܓܢܝܐ ܕܥܘܕܪ̈ܢܐ ܕܗܝܪ̈ܬܐ ܠܡܬܠ ܡܘܕܥܢܘܬܐ ܒܕܘܟܬ̈ܐ ܕܡܨܝ ܡܛܝܬܐ ܒܗܘܢ
ܠܐܬܘܬܐ ܒܡܓܢܐ. ܩܪܝ ܠ: (TTY:711) 1-800-801-1770 ܐܘ ܡܡܠܠ ܥܡ ܡܦܪ̈ܢܣܢܐ ܕܡܫܡܫܢܘܬܐ.

VIETNAMESE:
CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Các dịch vụ và sự hỗ trợ bổ sung thích hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi 1-800-801-1770 (TTY:711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

ALBANIAN:
VËMENDJE: Nëse flisni shqip, ju ofrohen shërbime falas për ndihmë gjuhësore. Gjithashtu, ofrohen falas ndihma dhe shërbimet ndihmëse përkatëse për të ofruar informacione në formate të aksesueshme. Telefononi në numrin 1-800-801-1770 (TTY:711) ose flisni me ofruesin tuaj të shërbimit.

KOREAN:
주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-800-801-1770 (TTY: 711)으로 전화하거나 서비스 제공자에게 문의하십시오.

BENGALI:
মনোযোগ: আপনি যদি বাংলা ভাষায় কথা বলেন তবে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-800-801-1770 (TTY:711) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

POLISH:
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer 1-800-801-1770 (TTY: 711) lub porozmawiać z lekarzem prowadzącym.

GERMAN:
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-800-801-1770 (TTY:711) an oder sprechen Sie mit Ihrem Dienstleister.

ITALIAN:
ATTENZIONE: Se parli italiano, sono a tua disposizione servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-801-1770 (TTY:711) o parla con il tuo fornitore.

JAPANESE:
ご案内: 日本語を話される方の場合、無料で言語支援サービスをご利用いただけます。また、情報をわかりやすい形式でご提供するための補助機器やサービスも無料でご利用いただけます。詳しくは、1-800-801-1770（TTY: 711）までお電話いただくか、担当の医療提供者にご相談ください。

RUSSIAN:
ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру 1-800-801-1770 (TTY:711) или обратитесь к своему врачу.

SERBIAN:
PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge jezičke pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima takođe su dostupni besplatno. Pozovite 1-800-801-1770 (TTY:711) ili se obratite pružaocu usluga.

TAGALOG:
PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Makukuha rin nang libre ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-801-1770 (TTY: 711) o makipag-usap sa iyong provider.

Employee Waiver of Coverage

Group ID _____

Employer _____

Employer Phone _____

I have been given the opportunity to apply for health care coverage in the Health Alliance Plan program offered to me by my employer. After serious consideration, I have decided not to apply for health care coverage in this program for the following reason:

- ☐ I have coverage through a spouse/parent
- ☐ I have coverage from a previous employer as a Retiree
- ☐ I am not choosing coverage due to affordability
- ☐ I have coverage through Exchange
- ☐ I have coverage through Medicare

_____ _____

Employee Signature Date

_____

Employee Name (please print)