2027 Summary of Benefits

Health Alliance Plan Medicare Advantage plans
PPO

January 1, 2027 - December 31, 2027



HAP Senior Plus (PPO)

HAP Medicare Explore (PPO)

Health Alliance Plan®
by Henry Ford Health

Pre-enrollment checklist

PPO Medicare Advantage plans

Health Alliance Plan®
by Henry Ford Health

Choosing a Medicare Advantage plan is an important decision. Taking a few minutes to review your coverage options before you enroll can help you find a plan that fits your healthcare needs and budget.

Have questions? We're here to help. Call and speak with a Customer Service representative at **(888) 658-2536 (TTY: 711)**. Representatives are available:

April 1 – Sept. 30: Monday – Friday, 8 a.m. to 8 p.m.
Oct. 1 – March 31: Seven days a week, 8 a.m. to 8 p.m.

Understanding the benefits

- ☐ Review the Evidence of Coverage (EOC) to understand your benefits and coverage, especially for the services and care you use regularly. For a copy of the EOC, visit **hap.org/planresources** or call Customer Service at the phone number above.
- ☐ Review the Provider Directory to make sure your doctors participate in the plan's network. If they aren't in our network, you may need to choose a new doctor. The Provider Directory is available at **hap.org/directory**.
- ☐ Review the Pharmacy Directory to make sure the pharmacy you use for prescription drugs is in the plan's network. If it is not, you may need to choose a new pharmacy for your prescriptions. The Pharmacy Directory is available at **hap.org/directory**.
- ☐ Review the Formulary (Drug List) to see if your medications are covered under the Part D benefit and whether any coverage restrictions apply. For the most current drug coverage information, visit **hap.org/planresources** or call Customer Service at the phone number above.

Important coverage information and rules

- ☐ Effect on Current Coverage: If you're enrolled in a Medicare Advantage plan, your current coverage will end when your new coverage starts. If you have TRICARE, your coverage may change when your new Medicare Advantage plan coverage starts. Contact TRICARE for details. If you have a Medicare Supplement (Medigap) plan, you may want to cancel it because you can't use it with a Medicare Advantage plan.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Our PPO plans allow you to see providers outside our network. However, those providers are not required to accept you as a patient unless you need emergency or urgent care. If they agree to treat you, the covered services will still be paid according to your plan, but you'll usually pay more than you would for care received from an in-network provider.

Health Alliance Plan of Michigan has HMO, HMO-POS and PPO plans with Medicare contracts. Enrollment depends on contract renewal.

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/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)** or **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.
- Covered 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 1-866-802-6746, (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, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Charlevoix, Clare, Clinton, Crawford, Eaton, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw, Wayne and Wexford.

The service area for **HAP Medicare Explore (PPO)** includes the following counties in Michigan: Allegan, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Charlevoix, Clare, Clinton, Crawford, Eaton, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw, Wayne and Wexford.

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.

If you use the providers that are not in our network, the plan may not pay for these services.

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.org/find-a-doctor).

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*.

- Our plan members get all of the benefits covered by Original Medicare. For Medicare-covered benefits, you will pay less in our plan than you would in Original Medicare.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in the booklet.
- **HAP Senior Plus (PPO)** and **HAP Medicare Explore (PPO)** are Medicare health plans with a Medicare contract. Enrollment depends on contract renewal.

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, https://www.hap.org/member-resources/medicare-resources/prescription-coverage/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 5 "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: Prescription Drug Deductible, Initial Coverage and Catastrophic Amount.

If you have any questions about these 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 continue to pay your Medicare Part B premium.	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	Medical Deductible: $0. Prescription Drug Deductible: $0.	Medical Deductible: $275. Prescription Drug Deductible: $400 for Tiers 3-5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $4,450 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: • $6,050 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		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
Inpatient Hospital	**In-Network:** Days 1-5: $250 Copay per day for each admission. Days 6-90: $0 Copay per day for each admission. Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per stay. Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules may apply.	**In-Network:** Days 1-6: $390 Copay after deductible per day for each admission. Days 7-90: $0 Copay after deductible per day for each admission. Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per stay. Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules may apply.
Outpatient Hospital	**In-Network:** $200 Copay per visit for surgical services. $100 Copay per visit for non-surgical services. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per visit for surgical and non-surgical services. Prior authorization rules may apply.	**In-Network:** $350 Copay after deductible per visit for surgical services. $160 Copay after deductible per visit for non-surgical services. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per visit for surgical and non-surgical services. Prior authorization rules may apply.
Ambulatory Surgical Center	**In-Network:** $180 Copay per visit. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per visit. Prior authorization rules may apply.	**In-Network:** $325 Copay after deductible per visit. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per visit. Prior authorization rules may apply.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
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: $50 Copay per visit. **Out-of-Network:** Primary care physician visit: 40% Coinsurance after deductible per visit. Specialist visit: 40% Coinsurance after deductible 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 after deductible per visit.
Emergency Care (world-wide)	**In-Network and Out-of-Network:** $150 Copay per visit. Copay waived if admitted to the hospital.	**In-Network and Out-of-Network:** $130 Copay per visit. Copay waived if admitted to the hospital.
Urgently Needed Services (world-wide)	**In-Network and Out-of-Network:** $65 Copay per visit.	**In-Network and Out-of-Network:** $50 Copay per visit.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $150 Copay per visit. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $150 Copay per visit. X-rays: $35 Copay per visit. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance per visit.	**In-Network:** Diagnostic tests and procedures: $200 Copay after deductible per visit. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $275 Copay after deductible per visit. X-rays: $35 Copay after deductible per visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
	Prior authorization rules may apply. **Out-of-Network:** Diagnostic tests and procedures: 25% Coinsurance per visit. Lab services: 25% Coinsurance per visit. Diagnostic Radiology Services (such as MRI, CAT Scan): 25% Coinsurance per visit. X-rays: 25% Coinsurance per visit. Therapeutic radiology services (such as radiation treatment for cancer): 25% Coinsurance per visit. Prior authorization rules may apply.	Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance after deductible per visit. Prior authorization rules may apply. **Out-of-Network:** Diagnostic tests and procedures: 40% Coinsurance after deductible per visit. Lab services: 40% Coinsurance after deductible per visit. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% Coinsurance after deductible per visit. X-rays: 40% Coinsurance after deductible per visit. Therapeutic radiology services (such as radiation treatment for cancer): 40% Coinsurance after deductible per visit. Prior authorization rules may apply.
Hearing Services	**In-Network:** $0 Copay for Medicare-covered hearing exam from a primary care provider. $25 Copay for Medicare-covered hearing exam from a specialty care provider. **Out-of-Network:** 25% Coinsurance for Medicare-covered hearing exam from a primary care provider. 25% Coinsurance for Medicare-covered hearing exam from a specialty care provider.	**In-Network:** $0 Copay for Medicare-covered hearing exam from a primary care provider. $50 Copay for Medicare-covered hearing exam from a specialty care provider. **Out-of-Network:** 40% Coinsurance after deductible for Medicare-covered hearing exam from a primary care provider. 40% Coinsurance after deductible for Medicare-covered hearing exam from a specialty care provider.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
	We partner with NationsHearing for these non-Medicare covered hearing services: Routine hearing exam (up to 1 visit(s) every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): $0 - $1,575 Copay. **For out-of-network non-Medicare covered hearing services:** Out-of-network providers are not part of our contracted hearing network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use NationsHearing providers. Same limits apply as in-network for supplemental hearing services. See EOC for more information.	**We partner with NationsHearing for these non-Medicare covered hearing services:** Routine hearing exam (up to 1 visit(s) every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): $0 - $1,575 Copay. **For out-of-network non-Medicare covered hearing services:** Out-of-network providers are not part of our contracted hearing network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use NationsHearing providers. Same limits apply as in-network for supplemental hearing services. See EOC for more information.
Dental Services	**In-Network:** $0 Copay for Medicare-covered dental services from a primary care provider. $25 Copay for Medicare-covered dental services from a specialty care provider. **Out-of-Network:** 25% Coinsurance for Medicare-covered dental services from a primary care provider. 25% Coinsurance for Medicare-covered dental services from a specialty care provider.	**In-Network:** $0 Copay for Medicare-covered dental services from a primary care provider. $50 Copay for Medicare-covered dental services from a specialty care provider. **Out-of-Network:** 40% Coinsurance after deductible for Medicare-covered dental services from a primary care provider. 40% Coinsurance after deductible for Medicare-covered dental services from a specialty care provider.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
	<u>We partner with Delta Dental (PPO provider network) for these non-Medicare covered dental services:</u> $0 Copay for the following dental services: 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, and 1 set of bitewings per calendar year. 50% Coinsurance for simple extractions, oral surgery, root canals and fillings. See the EOC for more details on this benefit. Maximum benefit of $1,500 per calendar year for all dental services. **<u>For out-of-network non-Medicare covered dental services:</u>** Out-of-network providers are not part of our contracted dental network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use Delta Dental PPO providers. Same limits apply as in-network for supplemental dental services. See EOC for more information.	**<u>We partner with Delta Dental (PPO provider network) for these non-Medicare covered dental services:</u>** $0 Copay for the following dental services: 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, and 1 set of bitewings per calendar year. 50% Coinsurance for simple extractions, oral surgery, root canals and fillings. See the EOC for more details on this benefit. Maximum benefit of $1,500 per calendar year for all dental services. **<u>For out-of-network non-Medicare covered dental services:</u>** Out-of-network providers are not part of our contracted dental network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use Delta Dental PPO providers. Same limits apply as in-network for supplemental dental services. See EOC for more information.
OPTIONAL SUPPLEMENTAL DENTAL PLAN (PURCHASED SEPARATELY)		
Services must be provided by a dentist in the Delta Dental Medicare Advantage PPO™ and Medicare Advantage Premier networks in Michigan, Ohio and Indiana.		
Optional Plan Name	Delta Dental PPO Plan	Delta Dental PPO Plan

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
OPTIONAL SUPPLEMENTAL DENTAL SERVICES (Continued)		
Monthly Plan Premium	If you elect this optional supplemental benefit, you will pay an additional $48.50 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.	If you elect this optional supplemental benefit, you will pay an additional $48.50 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.
Deductible	There is no deductible.	There is no deductible.
Plan Coverage	Covered preventive diagnostic services: 100% Covered comprehensive services: 50% See the EOC for more details on this benefit.	Covered preventive diagnostic services: 100% Covered comprehensive services: 50% See the EOC for more details on this benefit.
Maximum Plan Coverage	This dental plan will pay up to $2,000 maximum plan coverage limit per calendar year.	This dental plan will pay up to $2,000 maximum plan coverage limit per calendar year.
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)		
Vision Services	**In-Network:** $0 Copay for Medicare-covered eye exams from a primary care provider. $25 Copay for Medicare-covered eye exams from a specialty care provider. $0 Copay for Medicare-covered standard eye wear after cataract surgery. **Out-of-Network:** 25% Coinsurance for Medicare-covered vision services from a primary care provider. 25% Coinsurance for Medicare-covered vision services from a specialty care provider.	**In-Network:** $0 Copay for Medicare-covered eye exams from a primary care provider. $50 Copay for Medicare-covered eye exams from a specialty care provider. $0 Copay for Medicare-covered standard eye wear after cataract surgery. **Out-of-Network:** 40% Coinsurance after deductible for Medicare-covered vision services from a primary care provider. 40% Coinsurance after deductible for Medicare-covered vision services from a specialty care provider.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
	We partner with EyeMed for these non-Medicare covered vision services: $0 Copay for routine eye exam (up to 1 visit every year). 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. **For out-of-network non-Medicare covered vision services:** Out-of-network providers are not part of our contracted vision network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use EyeMed Insight network providers. Same limits apply as in-network for supplemental vision services. See EOC for more information.	**We partner with EyeMed for these non-Medicare covered vision services:** $0 Copay for routine eye exam (up to 1 visit every year). 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. **For out-of-network non-Medicare covered vision services:** Out-of-network providers are not part of our contracted vision network. You may see an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use EyeMed Insight network providers. Same limits apply as in-network for supplemental vision services. See EOC for more information.
Mental Health Services	**In-Network:** $0 Copay per visit for outpatient mental health therapy. $250 Copay for days 1-5 for inpatient mental health care in a psychiatric hospital. Days 6-90: $0 Copay per day for inpatient mental health care in a psychiatric hospital. Our plan covers 190 lifetime days for an inpatient mental health hospital stay. Prior authorization rules may apply.	**In-Network:** $15 Copay per visit for outpatient mental health therapy. $390 Copay after deductible for days 1-6 for inpatient mental health care in a psychiatric hospital. Days 7-90: $0 Copay after deductible per day for inpatient mental health care in a psychiatric hospital. Our plan covers 190 lifetime days for an inpatient mental health hospital stay. Prior authorization rules may apply.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
	Out-of-Network: 25% Coinsurance per visit. Our plan covers 190 lifetime days for an inpatient mental health hospital stay. Prior authorization rules may apply.	**Out-of-Network:** 40% Coinsurance after deductible per visit. Our plan covers 190 lifetime days for an inpatient mental health hospital stay. Prior authorization rules may apply.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $10 Copay per day. Days 21-100: $221 Copay per day. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per stay. Prior authorization rules may apply.	**In-Network:** Days 1-20: $10 Copay per day. Days 21-100: $221 Copay per day. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per stay. Prior authorization rules may apply.
Physical Therapy, Occupational Therapy, Speech Therapy	**In-Network:** $20 Copay per therapy visit. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per therapy visit. Prior authorization rules may apply.	**In-Network:** $45 Copay per therapy visit. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per therapy visit. Prior authorization rules may apply.
Ambulance	**In-Network and Out-of-Network:** $250 Copay for Medicare-covered ambulance services per trip. Must have prior authorization for non-emergency ambulance services.	**In-Network and Out-of-Network:** $300 Copay for Medicare-covered ambulance services per trip. Must have prior authorization for non-emergency ambulance services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Benefits/Services	**HAP Senior Plus (PPO)**	**HAP Medicare Explore (PPO)**
Medicare Part B Drugs	**In-Network:** 0% - 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 Coinsurance cap of $35 for one month's supply of insulin with no deductible. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance for Part B drugs. Step therapy requirements may apply to certain Part B drugs. Insulins covered under Medicare Part B are subject to a Coinsurance cap of $35 for one month's supply of insulin with no deductible. Prior authorization rules may apply.	**In-Network:** 0% - 20% Coinsurance after deductible 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 Coinsurance cap of $35 for one month's supply of insulin with no deductible. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible for Part B drugs. Step therapy requirements may apply to certain Part B drugs. Insulins covered under Medicare Part B are subject to a Coinsurance cap of $35 for one month's supply of insulin with no deductible. Prior authorization rules may apply.

PRESCRIPTION DRUG BENEFITS

	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information. **Important Message About What You Pay for Insulin -** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. **Important Message About Medicare Prescription Payment Plan -** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at 1-866-845-1803, (TTY: 1 (800) 716-3231) or visit Medicare.gov		
Prescription Drug Deductible	$0	$400 for Tiers 3-5

Initial Coverage

You pay the following until your total yearly drug costs reach $2,400. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

	Standard Retail Cost-Sharing	Standard Retail Cost-Sharing
Tier	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$9 Copay	$9 Copay
Tier 2 (Generic)	$15 Copay	$15 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance
Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	29% Coinsurance
Tier	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$18 Copay	$18 Copay
Tier 2 (Generic)	$30 Copay	$30 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance
Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$27 Copay	$27 Copay
Tier 2 (Generic)	$45 Copay	$45 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance

Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
	Preferred Retail Cost-Sharing	**Preferred Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$9 Copay	$9 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	29% Coinsurance
Tier	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$18 Copay	$18 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$27 Copay	$27 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
	Standard Mail Order	**Standard Mail Order**
Tier	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$9 Copay	$9 Copay
Tier 2 (Generic)	$15 Copay	$15 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance
Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	29% Coinsurance
Tier	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$18 Copay	$18 Copay
Tier 2 (Generic)	$30 Copay	$30 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance
Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance

Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$27 Copay	$27 Copay
Tier 2 (Generic)	$45 Copay	$45 Copay
Tier 3 (Preferred Brand)	22% Coinsurance	22% Coinsurance
Tier 4 (Non-Preferred Drug)	45% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
	Preferred Mail Order	**Preferred Mail Order**
Tier	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$9 Copay	$9 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	33% Coinsurance	29% Coinsurance
Tier	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$18 Copay	$18 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	43% Coinsurance	40% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Your cost-sharing may be different if you use a Long-Term Care pharmacy, an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.hap.org/forms) for complete information about your costs for covered drugs.

Catastrophic Amount

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay:

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
- You will pay the copay you paid during the Initial Coverage Stage for drugs not normally covered by the Part D (Enhanced Drugs). These drugs are identified as “ED” in the formulary.

ADDITIONAL COVERED BENEFITS	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
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. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance for acupuncture services per visit, 20 visit limit. Prior authorization rules may apply.	**In-Network:** $0 Copay for acupuncture services for chronic low back pain from a primary care physician per visit, 20 visit limit. $50 Copay for acupuncture services for chronic low back pain from a specialist provider per visit, 20 visit limit. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible for acupuncture services per visit, 20 visit limit. Prior authorization rules may apply.
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 every year performed by a chiropractor. **Out-of-Network:** 25% Coinsurance for chiropractic care per visit.	**In-Network:** $15 Copay after deductible 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 after deductible for one set of chiropractic x-rays every year performed by a chiropractor. **Out-of-Network:** 40% Coinsurance after deductible for chiropractic care per visit.
Companion Care	Not Covered.	Not Covered.

ADDITIONAL COVERED BENEFITS	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
Diabetes Management	**In-Network:** $0 Copay per visit. **Out-of-Network:** 25% Coinsurance for diabetes management per visit.	**In-Network:** $0 Copay per visit. **Out-of-Network:** 40% Coinsurance after deductible for diabetes management per visit.
Diabetes Supplies and Services	**In-Network:** $0 Copay for diabetes supplies and services per visit. $0 Copay for continuous glucose monitors (CGM) obtained at a pharmacy. **Out-of-Network:** 25% Coinsurance for diabetes supplies, CGM, and services per visit.	**In-Network:** $0 Copay for diabetes supplies and services per visit. $0 Copay for continuous glucose monitors (CGM) obtained at a pharmacy. **Out-of-Network:** 40% Coinsurance after deductible for diabetes supplies, CGM, and services per visit.
Dialysis Treatments	**In-Network:** 20% Coinsurance for each Medicare-covered outpatient dialysis treatment. **Out-of-Network:** 25% Coinsurance for each Medicare-covered outpatient dialysis treatment.	**In-Network:** 20% Coinsurance for each Medicare-covered outpatient dialysis treatment. **Out-of-Network:** 40% Coinsurance after deductible for each Medicare- covered outpatient dialysis treatment.
Durable Medical Equipment *(continuous glucose monitors (CGM), wheelchairs, oxygen, etc.)*	**In-Network:** 20% Coinsurance per item from a DME provider. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per item from a DME provider. Prior authorization rules may apply.	**In-Network:** 20% Coinsurance per item from a DME provider. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per item from a DME provider. Prior authorization rules may apply.

ADDITIONAL COVERED BENEFITS	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
Fitness	**In-Network:** $0 Copay for the fitness benefit. We partner with One Pass for your fitness benefit. **Out-of-Network:** Out-of-network providers are not part of our contracted fitness network. You may use an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use the One Pass network of providers. Same limits apply as in-network for fitness services. See EOC for more information.	**In-Network:** $0 Copay for the fitness benefit. We partner with One Pass for your fitness benefit. **Out-of-Network:** Out-of-network providers are not part of our contracted fitness network. You may use an out-of-network provider; however, you will be responsible for any costs above our maximum reimbursement, which may be more than in-network costs. You will pay less out-of-pocket if you use the One Pass network of providers. Same limits apply as in-network for fitness services. See EOC for more information.
Flex Card	**In-Network:** $45 allowance per quarter for OTC (from our online OTC catalog or from a participating retail store). Please note, allowance does not rollover to the next quarter. See EOC for more information. **Out-of-Network:** Out-of-network providers are not part of our approved retail locations for the flex card. You can choose to visit these locations, but you will pay less out of pocket if you use your flex card at one of our approved retail locations. The same benefit limits and rules apply when using the flex card, no matter where you go. For more details, please refer to your Evidence of Coverage (EOC).	Not Covered.

ADDITIONAL COVERED BENEFITS	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
Foot Care *(podiatry services)*	**In-Network:** $0 Copay for preventive podiatry services condition specific for diabetes per visit. $25 Copay for all other podiatry services per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $0 Copay for preventive podiatry services condition specific for diabetes per visit. $50 Copay for all other podiatry services per visit. **Out-of-Network:** 40% Coinsurance after deductible per visit.
Home-Delivered Meals	Not Covered.	Not Covered.
Home Health Agency Care	**In-Network:** $0 Copay for home health agency care. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $0 Copay for home health agency care. **Out-of-Network:** 40% Coinsurance after deductible per visit.
Hospice	**In-Network:** 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 (PPO). $0 Copay for a one-time only hospice consultation with a primary care physician. **Out-of-Network:** 25% Coinsurance for a one-time only hospice consultation with a primary care physician.	**In-Network:** 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 (PPO). $0 Copay for a one-time only hospice consultation with a primary care physician. **Out-of-Network:** 40% Coinsurance after deductible for a one-time only hospice consultation with a primary care physician.

ADDITIONAL COVERED BENEFITS	HAP Senior Plus (PPO)	HAP Medicare Explore (PPO)
Outpatient Substance Abuse	**In-Network:** $0 Copay per visit. **Out-of-Network:** 25% Coinsurance per visit.	**In-Network:** $15 Copay per visit. **Out-of-Network:** 40% Coinsurance after deductible per visit.
Over-the-Counter (OTC) Items	Flex Card Benefit available.	Not Covered.
Personal Emergency Response System (PERS)	Not Covered.	Not Covered.
Prosthetic Devices ***(braces, artificial limbs, etc.)***	**In-Network:** 20% Coinsurance per item. Prior authorization rules may apply. **Out-of-Network:** 25% Coinsurance per item. Prior authorization rules may apply.	**In-Network:** 20% Coinsurance per item. Prior authorization rules may apply. **Out-of-Network:** 40% Coinsurance after deductible per item. Prior authorization rules may apply.
Telemedicine	Not Covered.	Not Covered.
Transportation	Not Covered.	Not Covered.
Visitor/Traveler Benefit	Enjoy in-network cost-sharing on plan-covered benefits when you visit any Medicare-participating provider in any of the 49 states outside of Michigan for up to 12 months.	Enjoy in-network cost-sharing on plan-covered benefits when you visit any Medicare-participating provider in any of the 49 states outside of Michigan for up to 12 months.

DISCLAIMERS

You can get this document for free in other formats, such as large print or audio. Call 1-888-658-2536, (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 of Michigan has HMO, HMO-POS and 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 Plan members, except in emergency situations. Please call our Customer Service 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 Alliance Health and Life Insurance Company.

Health Alliance Plan®
by Henry Ford Health

Nondiscrimination Notice

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

Health Alliance Plan 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 Health Alliance Plan's customer service:
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 Health Alliance Plan 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 Health Alliance Plan'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/

Health Alliance Plan®
by Henry Ford Health

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. تتوفَّر 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 مقدِّم 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:
ܐܬܘܢ ܕܫܡܝܢ ܐܢ ܐܢܬ ܡܬܟܠܡ ܐܬ ܠܫܢܐ ܕܐܪܡܝܐ ܐܝܟ ܕܡܬ ܥܡ ܐܢ ܫܘܠܛܢ ܐܢ ܠܫܢ ܐܬ ܠܫܢ ܐܬ ܠܫܢ ܐܬ

Health Alliance Plan®
by Henry Ford Health

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.

Health Alliance Plan®
by Henry Ford Health

Alliance Health and Life Insurance Company

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Health Alliance Plan by Henry Ford Health
Alliance Health and Life Insurance Company®
Effective July 1, 2026

Your protected health information (PHI)

PHI stands for protected health information. PHI can be used to identify you. It includes information such as your name, age, sex, address and member ID number, as well as your:

- Physical or mental health
- Healthcare services
- Payment for care

You can ask us to give your PHI to people you choose. To do this, fill out our release form. You can find it at hap.org/privacy.

Your privacy

Keeping your PHI safe is important to us. We're required by law to keep your PHI private. We must also tell you about our legal duties and privacy practices. This notice explains:

- How we use information about you
- When we can share it with others
- Your rights related to your PHI
- How you can use your rights

When we use the term "we" or "us" in this notice, we're referring to Health Alliance Plan by Henry Ford Health and its subsidiaries. This includes Alliance Health and Life Insurance Company.

How we protect your PHI

We protect your PHI in written, spoken and electronic form. Our employees and others who handle your information must follow our policies on privacy and technology use. Anyone who works for us must state that they have read these policies. And they must state that they will protect your PHI even after they leave our employment. Our employees and contractors can only use the PHI necessary to do their jobs. And they may not use or share your information except in the ways outlined in this notice.

Our use and disclosure of your PHI must comply with both Michigan and federal privacy laws regulations. There are also Michigan and federal laws and regulations that place additional restrictions on the use and disclosure of certain types of PHI, including PHI about mental health, substance abuse, HIV/AIDS conditions and certain genetic information.

For example, in most cases your written consent is needed before using or disclosing psychotherapy notes (if recorded or maintained by us), documents related to your use of Suboxone, sending you marketing information about third-party products or services for which we are receiving direct or indirect payment, or the sale of medical information about you, unless it is otherwise allowed by law. Your consent can always be revoked in writing, but it will not apply to any uses or disclosures that were made before you revoked your consent.

How we use or share your PHI

We only share your information with those who must know for:

- Treatment
- Payments
- Business tasks

Treatment

We may share your PHI with your doctors, hospitals or other providers to help them:

- Provide treatment. For example, if you're in the hospital, we may let them see records from your doctor.
- Manage your healthcare. For example, we might talk to your doctor to suggest a program that could help improve your health.

Payment

We may use or share your PHI to help us figure out who must pay for your medical bills. We may also use or share your PHI to:

- Collect premiums
- Determine which benefits you can get
- Figure out who pays when you have other insurance

Business tasks

As allowed by law, we may share your PHI with:

- Companies affiliated with us
- Other companies that help with our everyday work
- Others who help provide or pay for your healthcare

We may share your information with others who help us do business. If we do, they must keep your information private and secure. And they must return or destroy it when they no longer need it for our business.

It may be used to:

- Evaluate how good care is and how much it improves. This may include provider peer review.
- Make sure healthcare providers are qualified and have the right credentials.
- Review medical outcomes.
- Review health claims.
- Prevent, find and investigate fraud and abuse.

- Decide what is covered by your policy and how much it will cost. But, we are not allowed to use or share genetic information to do that.
- Do pricing and insurance tasks.
- Help members manage their healthcare and get help managing their care.
- Communicate with you about treatment options or other health-related benefits and services.
- Do general business tasks, such as quality reviews and customer service.

Other permitted uses
We may also be permitted or required to share your PHI:

With you
- To tell you about medical treatments and programs or health-related products and services that may interest you. For example, we might send you information on how to stop smoking or lose weight.
- For health reminders, such as refilling a prescription or scheduling tests to keep you healthy or find diseases early.
- To contact you, by phone or mail, for surveys. For example, each year we ask our members about their experience with us.

With a friend or family member
- With a friend, family member or other person who, by law, may act on your behalf. For example, parents can get information about their children covered in their health plans.
- With a friend or family member in an unusual situation, such as a medical emergency, if we think it's in your best interests. For example, if you have an emergency in a foreign country and can't contact us directly. In that case, we may speak with a friend or family member who is acting on your behalf.
- With someone who helps pay for your care. For example, if your spouse contacts us about a claim, we may tell him or her whether the claim has been paid.

With the government
- For public health needs in the case of a health or safety threat such as disease or a disaster.
- For U.S. Food and Drug Administration investigations. These might include probes into harmful events, product defects or product recalls.
- For health oversight activities authorized by law.
- For court proceedings and law enforcement uses.
- With the police or other authority in case of abuse, neglect or domestic violence.
- With a coroner or medical examiner to identify a body, find out a cause of death or as authorized by law. We may also share member information with funeral directors.
- To comply with workers' compensation laws.
- To report to state and federal agencies that regulate us and our subsidiaries. These may include the:
  - U.S. Department of Health and Human Services
  - Michigan Department of Insurance and Financial Services
  - Michigan Department of Health and Human Services
  - Federal Centers for Medicare and Medicaid Services
- To protect the U.S. president.

For research or transplants
- For research purposes that meet privacy standards. For example, researchers want to compare

outcomes for patients who took a certain drug and must review a series of medical records.
- To receive, bank or transplant organs, eyes or tissue.

With your employer or plan sponsor
We may use or share your PHI with an employee benefit plan through which you get health benefits. It is only shared when the employer or plan sponsor needs it to manage your health plan.

Except for enrollment information or summary health information and as otherwise required by law, we only share your PHI with an employer or plan sponsor if they have guaranteed in writing that it will be kept private and won't be used improperly.

To use or share your PHI for any other reason, we must get your written permission. If you give us permission, you may change your mind and cancel it. But it will not apply to information we've already shared.

Substance use disorder (SUD) records
We will not use or disclose your SUD records in legal proceedings against you unless:

- We receive your written consent, or
- We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.

Your Rights Regarding Part 2 Records
The additional patient rights outlined in this Notice apply to all medical information, including Part 2 records.

Treatment alternatives, health benefits, fundraising and marketing
We may use and disclose your PHI to contact you about treatment alternatives, health-related benefits, products or services or to provide gifts of nominal value to you or your family. We may also contact you to raise funds for Health Alliance Plan by Henry Ford Health or any of its subsidiaries or affiliates.

Organized healthcare arrangement
We as well as our affiliates are covered by this Notice of Privacy Practices and Henry Ford Health and its affiliates are part of an organized healthcare arrangement. Its goal is to deliver higher-quality healthcare more efficiently and to take part in quality measure programs, such as the Healthcare Effectiveness Data and Information Set. HEDIS is a set of standards used to measure the performance of a health plan. In other words, HEDIS is a report card for managed care plans.

The Henry Ford Health organized healthcare arrangement includes:
- Health Alliance Plan by Henry Ford Health
- Alliance Health and Life Insurance Company
- Henry Ford Health

Henry Ford's organized healthcare arrangement lets these organizations share PHI. This is only done if allowed by law and when needed for treatment, payment or business tasks relating to the organized healthcare arrangement. This list of organizations may be updated. You can access the current list at hap.org/privacy or call us at (800) 422-4641 (TTY: 711). When required, we will tell you about any changes in a revised Notice of Privacy Practices.

Your rights
These are your rights with respect to your information. If you would like to exercise any of these rights, please contact us. The contact information is in the "Who to contact" section at the end of this document. You may have to make your requests in writing.

You have the following rights:

Right to see your PHI and get a copy
With some exceptions, you have the right to see or get a copy of PHI in records we use to make decisions about your health coverage. This includes our enrollment, payment, claims resolutions and case or medical management notes. If we deny your request, we'll tell you why and whether you have a right to further review.

You may have to fill out a form to get PHI and pay a fee for copies. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to ask us to change your PHI
If we deny your request for changes in PHI, we'll explain why in writing. If you disagree, you may have your disagreement noted in our records. If we accept your request to change the information, we'll make reasonable efforts to tell others of the change, including people you name. In this case, the information you give us must be correct. And we cannot delete any part of a legal record, such as a claim submitted by your doctor.

Right to know about disclosures
You have the right to know about certain disclosures of your PHI. We do not have to inform you of all PHI we release. We are not required to tell you about PHI shared or used for treatment, payment and business tasks. And we do not have to tell you about information we shared with you or based on your authorization. But you may request a list of other disclosures made during the six years prior to your request.

Your first list in any 12-month period is free. However, if you ask for another list within 12 months of receiving your free list, we may charge you a fee. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to know about data breaches that compromise your PHI
If there is a breach of your unsecured PHI, we'll tell you about it as required by law or in cases when we deem it appropriate.

Right to ask us to limit how we use or share your PHI
You may ask us to limit how we use or share your PHI for treatment, payment or business tasks. You also have the right to ask us to limit PHI shared with family members or others involved in your healthcare or payment for it. We do not have to agree to these limits. But if we do, we'll follow them – unless needed for emergency treatment or the law requires us to share your PHI. In that case, we will tell you that we must end our agreement.

Right to request private communications
If you believe that you would be harmed if we send your PHI to your current mailing address (for example, in

a case of domestic dispute or violence), you can ask us to send it another way. We can send it by fax or to another address. We will try to meet any fair requests.

You have a right to get a paper copy of this notice.

Opt-Out Options

We may use and disclose your medical information in a Health Information Exchange (HIE), when raising funds or conducting marketing campaigns as described in the sections above. In regard to fundraising, Health Alliance Plan or our OHCA Members may participate in these activities and we ask that you aid us in our efforts, while being confident that we are protecting your medical information. If you wish to opt-out of any of these activities, you have the right to request to do so in writing. If after choosing to opt-out you wish to opt-back-in, you may also do so in writing.

Changes to the privacy statement

We have the right to make changes to this notice. If we make changes, the new notice will be effective for all the PHI we have. Once we make changes, we'll send you the new notice by U.S. mail and post it on our website.

Who to contact

To exercise any of the rights listed above, contact Customer Service at (800) 422-4641 (TTY: 711)

To opt out, opt back in or object to a specific use or disclosure, or if you have any questions about this notice or about how we use or share member information, please send a written request to:

Mail: Health Alliance Plan by Henry Ford Health
Information Privacy & Security Office
One Ford Place
Detroit, MI 48202

Email: privacysecurity@hfhs.org
Fax: (313) 874-9449

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us. Contact the Information Privacy & Security Office above or our Compliance Hotline at (877) 746-2501 (TTY: 711) or henryfordhealth.ethicspoint.com. You can stay anonymous. You may also notify the secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Original effective date: April 13, 2003
Revisions: February 2005, November 2007, September 2013, September 2014, March 2015, October 2015, October 2018, August 2023, September 2024, September 2025, February 2026, July 2026
Reviewed: November 2008, November 2009, October 2011, January 2019, August 2020, September 2021, October 2022, August 2023, September 2024, September 2025, February 2026, July 2026

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At Health Alliance Plan, we're committed to helping you choose the right option for you. *Call today!*

Health Alliance Plan Sales Agent

(866) 802-6746 (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 Health Alliance Plan 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/ppocare**



Health Alliance Plan®
by Henry Ford Health