Subject: Updates to your 2024 Medicare Advantage plan

Dear Valued Member,

As you are part of our HAP family, we want to keep you informed about some changes to your Medicare Advantage plan for 2024.

What's changing?

Your current plan is being updated to a new HAP Medicare Advantage plan for 2024. Here's what that means for you:

1) New benefits: You may have access to additional services and features that better suit your health care needs.

2) Changes in costs: Your monthly payment, or the amount you pay when you see a doctor or fill a prescription, might change. All these details are in the enclosed document.

3) Same trusted care: You'll continue to have access to the same doctors and health care providers you trust.

What's next?

Please take a moment to read the enclosed document, called the Annual Notice of Changes (ANOC). It explains all the specific changes to your plan.

If anything is unclear or if you have questions, please call HAP at the number on the back of the enclosed ANOC.

You can also find more information on our website at hap.org/medicare.

We're here for you

At HAP, your health is our priority. We're committed to providing you with the best care and support. Thank you for trusting us with your health care needs, and we look forward to being there for you in the coming year.

Sincerely,

HAP Customer Service

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

Y0076_ALL 2024 ANOC letter_C

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HAP Senior Plus (PPO) offered by Alliance Health and Life Insurance Company

Annual Notice of Changes for 2024

You are currently enrolled as a member of *HAP Senior Plus*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.hap.org/medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

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☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in *HAP Senior Plus*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with *HAP Senior Plus*.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Service number at (888) 658-2536 for additional information. (TTY users should call 711). Hours are April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week. This call is free.
- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- This booklet is available in alternate formats such as large print or audio.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HAP Senior Plus

- *Health Alliance Plan (HAP)* has HMO, HMO-POS, PPO plans with Medicare contracts. Enrollment depends on contract renewal.
- When this document says "we," "us," or "our", it means *Health Alliance Plan (HAP).* When it says "plan" or "our plan," it means *HAP Senior Plus*.

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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for *HAP Senior Plus (PPO)* in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$180	$165
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: $4,000 From network and out-of-network providers combined: $6,100	From network providers: $4,000 From network and out-of-network providers combined: $4,000
Doctor office visits	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $25 Copay per visit **Out-of-Network** Primary care visits: 20% Coinsurance per visit Specialist visits: 20% Coinsurance per visit	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $25 Copay per visit **Out-of-Network** Primary care visits: 25% Coinsurance per visit Specialist visits: 25% Coinsurance per visit

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network** $145 Copay per day for days 1-7 $0 Copay per day for days 8- 90 **Out-of-Network** You pay 20% Coinsurance per admission	**In-Network** $250 Copay per day for days 1 - 5 $0 Copay per day for days 6 - 90 **Out-of-Network** You pay 25% Coinsurance per admission
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copays/coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost sharing:* $9 *Preferred cost sharing:* $0 • Drug Tier 2: *Standard cost sharing:* $17 *Preferred cost sharing:* $12 • Drug Tier 3: *Standard cost sharing:* $47 (Select Insulins: $25) *Preferred cost sharing:* $42 (Select Insulins: $10) • Drug Tier 4: *Standard cost sharing:* 50% *Preferred cost sharing:* 48%	Deductible: $0 Copays/coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost sharing:* $9 *Preferred cost sharing:* $0 • Drug Tier 2: *Standard cost sharing:* $17 *Preferred cost sharing:* $11 • Drug Tier 3: *Standard cost sharing:* $47 You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* $41 You pay $25 per month supply of each covered insulin product on this tier. • Drug Tier 4: *Standard cost sharing:* 50% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 48%

Cost	2023 (this year)	2024 (next year)
		You pay $25 per month supply of each covered insulin product on this tier.
	• Drug Tier 5: *Standard cost sharing:* 33% *Preferred cost sharing:* 33%	• Drug Tier 5: *Standard cost sharing:* 33% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 33% You pay $25 per month supply of each covered insulin product on this tier.
	• Drug Tier 6: *Standard cost sharing:* $0 *Preferred cost sharing:* $0	• Drug Tier 6: *Standard cost sharing:* $0 *Preferred cost sharing:* $0
	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.).	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *HAP Senior Plus (PPO)* in 2024

On January 1, 2024, *Health Alliance Plan (HAP)* will be combining *HAP Senior Plus Option 4 (PPO)* with one of our plans, *HAP Senior Plus (PPO)*. The information in this document tells you about the differences between your current benefits in *HAP Senior Plus Option 4 (PPO)* and the benefits you will have on January 1, 2024 as a member of *HAP Senior Plus (PPO)*.

If you do nothing by December 7, 2023, we will automatically enroll you in our *HAP Senior Plus*. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through *HAP Senior Plus*. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$180	$165
Optional dental plan monthly premium	Delta Dental Plan 50 Member Pays $20.00 per month Delta Dental Plan 70 Member Pays $39.30 per month Delta Dental Plan 100 Member Pays $46.60 per month	Delta Dental 50 Member Pays $19.10 per month Delta Dental 70 Member Pays $29.50 per month Delta Dental 100 Member Pays $51.90 per month

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

Cost	2023 (this year)	2024 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. If you choose an optional supplemental dental plan, your plan premium and your costs for services also do not count toward your maximum out-of-pocket amount.	$4,000	$4,000 Once you have paid $4,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services. If you choose an optional supplemental dental plan, your plan premium and your costs for services also do not count toward your maximum out-of-pocket amount.	$6,100	$4,000 Once you have paid $4,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at hap.providerlookuponlinesearch.com/search. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Ambulance Services	**In-Network:** You pay a $175 copay for ambulance services per trip. **Out-of-Network:** You pay 20% coinsurance of the total cost for this benefit.	**In-Network:** You pay a $250 copay for ambulance services per trip. **Out-of-Network:** You pay 25% coinsurance of the total cost for ambulances services per trip.

Cost	2023 (this year)	2024 (next year)
Ambulatory Surgical Center (ASC) Services	**In-Network:** You pay a $95 copay for ASC services per visit. **Out-of-Network:** You pay a 20% coinsurance of the total cost for ASC services per visit.	**In-Network:** You pay a $180 copay for ASC services per visit. **Out-of-Network:** You pay a 25% coinsurance of the total cost for ASC services per visit.
Chiropractic Services	**In-Network:** You pay a $20 copay for chiropractic services per visit. Office visit and chiropractic x-rays are not covered. **Out-of-Network:** You pay 20% coinsurance of the total cost for chiropractic services per visit. Office visit and chiropractic x-rays are not covered.	**In-Network:** You pay a $20 copay for chiropractic services and office visit per visit. You pay a $35 copay for one set of chiropractic x-rays. Office visit and chiropractic x-rays are limited to one per year. **Out-of-Network:** You pay 25% coinsurance of the total cost for chiropractic services (including office visit and x-rays) per visit. Office visit and chiropractic x-rays are limited to one per year.
Eyewear	You get a $130 allowance for eyewear per year, must be obtained from an EyeMed provider.	You get a $150 allowance for eyewear per year, must be obtained from an EyeMed provider.
Inpatient Hospital Stays	**In Network:**	**In Network:**

Cost	2023 (this year)	2024 (next year)
	You pay a $145 copay per day for days 1-7 per admission. **Out-of-Network:** You pay 20% coinsurance of the total cost per day per admission	You pay a $250 copay per day for days 1-5 per admission. **Out-of-Network:** You pay 25% coinsurance of the total cost per day per admission
Outpatient Diagnostic Procedures/Tests/Lab Services	**In-Network:** You pay a $100 copay for outpatient diagnostic radiological services per visit. **Out-of-Network:** You pay 20% coinsurance of the total cost for outpatient diagnostic procedures/tests/lab services per visit.	**In-Network:** You pay a $150 copay for outpatient diagnostic radiological services per visit. **Out-of-Network:** You pay 25% coinsurance of the total cost for outpatient diagnostic procedures/tests/lab services per visit.
Outpatient Diagnostic Radiological Services	**In-Network:** You pay a $125 copay for outpatient diagnostic radiological services (such as CT/MRI) per visit. **Out-of-Network:** You pay 20% coinsurance of the total cost for outpatient diagnostic radiological services (such as CT/MRI) per visit.	**In-Network:** You pay a $150 copay for outpatient diagnostic radiological services (such as CT/MRI) per visit. **Out-of-Network:** You pay 25% coinsurance of the total cost for outpatient diagnostic radiological services (such as CT/MRI) per visit.

Cost	2023 (this year)	2024 (next year)
Outpatient Hospital Services and Outpatient Observation Services	**In-Network:** You pay a $155 copay for outpatient hospital services and outpatient observation services per visit. **Out-of-Network:** You pay 20% coinsurance of the total cost for outpatient hospital services and outpatient observation services per visit.	**In-Network:** You pay a $200 copay for outpatient hospital services and outpatient observation services per visit. **Out-of-Network:** You pay 25% coinsurance of the total cost for outpatient hospital services and outpatient observation services per visit.
Over-the-Counter (OTC) Items	Food and produce are not covered.	Food and produce are covered. Must use NationsOTC.
Physical, Occupational or Speech Therapy Services	**In-Network:** You pay nothing for therapy services per visit. **Out-of-Network:** You pay 20% coinsurance of the total cost for therapy services per visit.	**In-Network:** You pay a $15 copay for therapy services per visit. **Out-of-Network:** You pay 25% coinsurance of the total cost for therapy services per visit.
Skilled Nursing Facility (SNF)	**In Network:** You pay a $196 copay for days 21-100 for SNF care. **Out-of-Network:** You pay 20% coinsurance of the total cost for days 21-100 for SNF care.	**In Network:** You pay a $203 copay for days 21-100 for SNF care. **Out-of-Network:** You pay 25% coinsurance of the total cost for days 21-100 for SNF care.

Cost	2023 (this year)	2024 (next year)
Therapeutic Radiological Services	**In-Network:** You pay a $30 copay for therapeutic radiological services. **Out-of-Network:** You pay 20% of the total cost for therapeutic radiological services.	**In-Network:** You pay a $40 copay for therapeutic radiological services. **Out-of-Network:** You pay 25% coinsurance for therapeutic radiological services.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List." is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List." to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate

insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Customer Service and ask for the LIS Rider.

There are four **drug payment stages.** The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Tier drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply; at a network pharmacy that offers	Your cost for a one-month supply at a network pharmacy with standard cost sharing: **Preferred Generics:** *Standard cost sharing:* You pay $9 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Generics:** *Standard cost sharing:* You pay $17 per prescription. *Preferred cost sharing:* You pay $12 per prescription.	Your cost for a one-month supply at a network pharmacy with standard cost sharing: **Preferred Generics:** *Standard cost sharing:* You pay $9 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Generics:** *Standard cost sharing:* You pay $17 per prescription. *Preferred cost sharing:* You pay $11 per prescription.

Stage	2023 (this year)	2024 (next year)
preferred cost sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.* We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription.	**Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay $41 per prescription. You pay $25 per month supply of each covered insulin product on this tier.
	Non-Preferred Brand: *Standard cost sharing:* You pay 50% of the total cost. *Preferred cost sharing:* You pay 48% of the total cost.	**Non-Preferred Brand:** *Standard cost sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 48% of the total cost. You pay $25 per month supply of each covered insulin product on this tier.
	Specialty Tier: *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.	**Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 33% of the total cost. You pay $25 per month supply of each covered insulin product on this tier.
	Select Care Drugs:	**Select Care Drugs:**

Stage	2023 (this year)	2024 (next year)
	Standard cost sharing: You pay $0 per prescription. *Preferred cost sharing:* You pay $0 per prescription. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	*Standard cost sharing:* You pay $0 per prescription. *Preferred cost sharing:* You pay $0 per prescription. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

HAP has administrative changes for 2024. The changes are summarized below.

Cost	2023 (this year)	2024 (next year)
Companion Care	You pay nothing for companion care. You must use NationsCare.	You pay nothing for companion care. You must use **Papa**.
Diabetes self-management training, diabetic services and supplies	HAP partners with Livongo for diabetes and hypertension management.	Livongo services will not be available. HAP will utilize its own care management programs to help you manage your diabetes and hypertension.
Fitness benefit	You pay nothing for the fitness benefit. You must use PeerFit Move.	You pay nothing for the fitness benefit. You must use **SilverSneakers**.
Post discharge meal benefit	Limited to 28 meals/14 days per discharge, with certain chronic conditions.	Limited to 2 discharges per year with 28 meals/14 days: max of 56 meals per year. No longer condition specific.
Service area	Service area consists of: Allegan, Arenac, Barry, Bay, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Newaygo, Oakland, Osceola, Saginaw, Sanilac, Shiawassee, St. Clair,	Service area consists of: 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,

Cost	2023 (this year)	2024 (next year)
	Tuscola, Washtenaw and Wayne	Oakland, **Oceana**, Osceola, **Ottawa**, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, **Van Buren**, Washtenaw and Wayne.
Ways to pay your plan premium	There are three ways you can pay your plan premium. 1. Paying by check 2. Automatically withdrawn from your bank account 3. Having plan premium taken out of your monthly Social Security check	There are three ways you can pay your plan premium. 1. Paying by check 2. **Register at hap.org/welcome and click "Pay My Bill" where you can view your invoice and make a one-time payment or set up recurring payments** 3. Having plan premium taken out of your monthly Social Security check

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in *HAP Senior Plus*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our *HAP Senior Plus.*

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

As a reminder, *Alliance Health and Life Insurance Company* offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *HAP Senior Plus.*
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *HAP Senior Plus.*
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
  - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Michigan Medicare/Medicaid Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Michigan Medicare/Medicaid Assistance Program at (800) 803-7174. You can learn more about Michigan Medicare/Medicaid Assistance Program by visiting their website (www.mmapinc.org).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual

deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:

 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free).

SECTION 8 Questions?

Section 8.1 – Getting Help from *HAP Senior Plus*

Questions? We're here to help. Please call Customer Service at (888) 658-2536. (TTY only, call 711.) We are available for phone calls April 1st through September 30th Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for *HAP Senior Plus.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.hap.org/medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.hap.org/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our List of Covered Drugs (Formulary/"Drug List").

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

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.

HAP
Alliance Health and Life Insurance Company®
HAP Empowered Health Plan, Inc.
Effective August 8, 2023

Your protected health information

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
- Health care services
- Payment for care

You can ask HAP 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 HAP. 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 "HAP," "we" or "us" in this notice, we're referring to HAP and its subsidiaries. These include Alliance Health and Life Insurance Company and HAP Empowered Health Plan, Inc.

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 starts working for HAP must state that they have read these policies. And they must state that they will protect your PHI even after they leave HAP. 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.

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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 3rd 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 health care. For example, we might talk to your doctor to suggest a HAP 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 HAP
- Other companies that help with HAP's everyday work
- Others who help provide or pay for your health care

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 health care 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 health care 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 HAP.

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 by HAP.
- 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.

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- 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 HAP and its 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.

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 or any of its subsidiaries or affiliates.

Organized health care arrangement

HAP and HAP affiliates covered by this Notice of Privacy Practices and Henry Ford Health and its affiliates are part of an organized health care arrangement. Its goal is to deliver higher quality health care 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 health care arrangement includes:

- HAP
- Alliance Health and Life Insurance Company
- HAP Empowered Health Plan, Inc.
- Henry Ford Health

Henry Ford's organized health care 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 health care 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. HAP does 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 health care 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.

Notice of Privacy Practices

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: HAP and HAP Empowered Information Privacy & Security Office, One Ford Place, Detroit, MI 48202**
- **Email: IPSO@hfhs.org**

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 HAP's Compliance Hotline at **(877) 746-2501 (TTY: 711)**. 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
Reviewed:November 2008, November 2009, October 2011, January 2019, August 2020, September 2021, October 2022, August 2023

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0033_NPP; Approved

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 **Medicare -** (800) 801-1770 (YYT: 711)

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 48038
- **Phone:** **General** - (800) 422-4641 **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/**

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-801-1770 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-801-1770 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-801-1770。(TTY 用户请致电 711。) 我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如果需要翻譯服務，請致電 1-800-801-1770。(TTY 專線：711。) 我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-801-1770 (TTY: 711.) Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-801-1770 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-801-1770 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-801-1770 an (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Form Approved
OMB# 0938-1421

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역서비스를 제공하고 있습니다통역 서비스를 이용하려면 전화 1-800-801-1770 (TTY: 711) 번으로 문의해 주십시오한국어를 하는 담당자가 도와 드릴 것입니다 이서비스는무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-801-1770 (телетайп: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: جا ملفوري المجانية للإجابة نع أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوا ىلاتصال بنا على 1-800-801-1770 (TTY: 711) م شخص ما يتحدثالعربية بمسعادتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी सवाल का जवाब देने के लिए हमारे पास मुफ़्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, हमें 1-800-801-1770 (TTY पर कॉल करें: 711). कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ़्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-801-1770 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-801-1770 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-801-1770 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-801-1770 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-801-1770 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

HAP Senior Plus Customer Service

Method	Customer Service – Contact Information
CALL	(888) 658-2536. Calls to this number are free. Our normal business hours are: April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
TTY	711. Calls to this number are free. Our normal business hours are: April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
WRITE	HAP Medicare Solutions, ATTN: Customer Service, 1414 East Maple Rd., Troy, MI 48083
WEBSITE	www.hap.org/medicare

Michigan Medicare/Medicaid Assistance Program

Michigan Medicare/Medicaid Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	(800) 803-7174
TTY	(888) 263-5897 Office hours are 8:00 am to 7:00 pm EST, Monday through Friday (except holidays).
WRITE	6105 W. St. Joseph Hwy., Suite 204, Lansing, MI 48917-4850
WEBSITE	www.mmapinc.org

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*