Genesee HEALTH SYSTEM
Hope and health in the community

MAIN CAMPUS
420 W. Fifth Avenue
Flint, MI 48503
Phone: (810) 257-3705
Toll Free: (866) 211-5455
Crisis Line: (877) 346-3648
www.genhs.org

November 5, 2021

RE: Medicare Eligible Retirees

Retiree Open Enrollment is under way 11/8/2021 through 11/19/2021. For the 2022 Plan Year, GHS is offering three Medicare Advantage Plans: Blue Cross Blue Shield Medicare Plus Blue Group, Health Alliance Plan Senior Plus HMO, and Health Alliance Plan Senior Plus PPO. **Please note, HAP Medicare Advantage plans only provide coverage (other than emergency services) in Michigan for the following 30 counties: Arenac, Bay, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Lapeer, Lenawee, Livingston, Macomb, Midland, Monroe, Montcalm, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw, and Wayne.** All Medicare Advantage plans wrap around Medicare parts A & B, and provide an additional Prescription Medication benefit. As in 2021, the Medicare Advantage insurance card will be used, rather than showing your paper Medicare Card.

Due to the ongoing Covid Pandemic, we are asking that you return enrollment forms by email or by using the self-addressed stamped envelope included with this letter. For anyone needing enrollment assistance you may utilize email, tplantz@genhs.org, or reach out to Tami directly at (810) 496-5603.

Critical: Review the page titled CMH/GHS Retiree Options. This document describes how the healthcare section made by the retiree affects the plan selections available to your eligible spouse or dependent, if applicable.

Open Enrollment documents will be posted on the GHS website at www.genhs.org near the bottom of the webpage in the blue highlighted section under USEFUL PAGES-CMH/GHS RETIREES tab.

Please review the enclosed information covering the three plan selections for the 2022 Plan Year. The Benefits at a Glance documents will all be posted on the Retiree Website. Medicare Advantage enrollees must **each** complete a **2022 GHS Enrollment Form**. Alternatively, if remaining in the same Medicare Advantage plan for 2022 as currently enrolled for 2021, please sign and return the **prefilled GHS Enrollment Form included with this letter**, sign and date the **No Dual Health Coverage** and complete the **Mutual of Omaha Beneficiary Form**. All appropriate documentation must be received in my office by **Monday, November 22, 2021**. I have included additional information with this letter which you may find informative and beneficial. Dental and vision coverage options remain the same as in 2021.

If you are a **new** Medicare Advantage enrollee or are **changing** your selection for 2022, you must complete the appropriate **Medicare Advantage Enrollment Application** (found on the website) and provide additional documents as requested on the Healthcare Enrollment Checklist. Please note that if you are switching Medicare Advantage Plans, you must include the appropriate Disenrollment Form (also found on the website).

If you have any questions or concerns, you may contact Tami Plantz at (810) 496-5603 or Sandy Sweet at (810) 496-5759.

Sincerely,

Sandra Sweet

Sandra Sweet, Accounting Manager
Genesee Health System

GENESEE HEALTH SYSTEM

2022 Enrollment Form: Retiree Medicare Enrollee ☐; Spouse ☐; Surv. Spouse ☐

Required: One GHS Enrollment Form **from *each*** MA enrollee

Retiree or Spouse Name:	Social Security #			
Address:	Telephone #			
City, State ZIP:	Date of Birth			

MEDICAL INSURANCE OPTIONS	**Single**			Effective Date			GHS Initials
Blue Cross Medicare Advantage	☐			(For Official Use Only)			
*HAP Senior Plus HMO (MI Residents Only)	☐						
*HAP Alliance Medicare PPO (MI Residents Only)	☐						
OPTICAL/DENTAL INSURANCE	**Single**	**Double**	**Family**				
Blue Cross of Michigan - Vision	☐	☐	☐	Effective Date			GHS Initials
Delta Dental of Michigan	☐	☐	☐	Effective Date			GHS Initials

List all persons to be enrolled:

Last Name (Print)	First Name	Relation	F/M	SSN			DOB	Primary Care Physician Required with HMO Only
		SELF						
		SPOUSE						
		DEPEND						

Please Note: Provisions and penalties described in the "No Dual Hospital/Medical Coverage Certification" form apply. (*Note: The HAP Medicare Advantage Plans are for MI residents only, please see enrollment letter for 30 county service area.)

GHS sponsored plans options:

1.) **Retiree and Spouse are both Medicare Advantage eligible:** Must enroll in the same Medicare Advantage plan (i.e. both select HAP Senior Plus HMO, or HAP Alliance Medicare PPO, or both select Blue Cross Medicare Advantage).

2.) **Medicare Advantage Retiree with an under 65 Spouse and/or Dependent:** Retiree Enrolls in HAP Senior Plus HMO or Blue Cross Medicare Advantage plan, Spouse and/or Dependent enroll in HAP High Deductible HMO. Retiree Enrolls in HAP Alliance Medicare PPO or Blue Cross Medicare Advantage plan, Spouse and/or Dependent enroll in the HAP High Deductible PPO plan.

I certify that I have read the important information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the healthcare contract void and refuse all allowance of the benefits to any person under the contract(s).

Retiree/Spouse Signature (Do Not Print)	Date	Employer's Signature	Date

NO DUAL HOSPITAL / MEDICAL COVERAGE CERTIFICATION

I have exercised my option to enroll in one of the Genesee Health System sponsored Hospital/Medical Plans. I understand that anyone enrolled in a High Deductible Health Plan (HDHP) covered under a Health Savings Account (HSA) is prohibited from participating in the plan if any one of those enrolled has other hospital/medical insurance. All enrollees are prohibited from having dual hospital/medical insurance due to federal requirements for participation in a HDHP w/ HSA. In addition, GHS prohibits retirees and anyone else on their hospital/medical policy from maintaining dual insurance coverage. Medicare Part A and/or Part B are still considered dual insurance unless enrolled into a Medicare Advantage (MA) plan sponsored by GHS. It is the responsibility of the retiree to notify the GHS Payroll Department within 30-days of being eligible or enrolled into Medicare, and provide this information annually during the annual open enrollment period. Failure to notify GHS of your (or your family members') Medicare eligibility and/or enrollment could result in negative federal tax implications for the retiree.

In accordance with the GHS prohibition against dual hospital/medical coverage, I hereby certify that neither I, my spouse, nor any dependent under age 19, nor any qualified adult child aged 19-26 listed on the enrollment application form have any other hospital/medical coverage. Regarding the possible enrollment of a qualified adult child aged 19-26, the child is governed by the rules associated with plans which qualify to be "grandfathered" or "not grandfathered". I also understand that if I have failed to disclose or falsified documentation regarding this paragraph, that GHS will bill me the amount overpaid by GHS for myself, spouse, dependent or qualified adult child aged 19-26 that was inappropriately dual covered. Falsification of documents constitutes fraud and is subject to termination.

I understand that GHS will require documentation of involuntary termination of coverage if I am transferring either my spouse, dependent, or qualified adult child aged 19-26 to a GHS hospital/medical plan from another employer paid source, outside the GHS open enrollment period.

I understand that I must notify the Payroll Department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be removed from my insurance. I also understand that if I do not comply with this rule that GHS will bill me the amount overpaid by GHS for a spouse, dependent, or qualified adult child aged 19-26 that should have been removed from my insurance. Charges will become effective as of the last day of the month in which the qualifying event occurs.

I understand that I must notify the Payroll Department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be added to my insurance. I also understand that if I do not comply with this rule, the spouse, dependent, or qualified child aged 19-26 must wait until the GHS open enrollment period to be added to my insurance.

For those considering the addition of a qualified adult child aged 19-26, you must obtain and sign the "Considerations for adding adult children aged 19-26" form from the GHS Payroll Department. If adult child is eligible to enroll in your group hospital/medical health plan, then coverage <u>will terminate on the last day of the month in which the child turns 26</u>, or child becomes otherwise ineligible.

_____
Name Printed

_____ _____ _____
Signature Date GHS INITIALS

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Genesee Health System	Group ID: G000B2R2

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	Email Address:
*City:	*State:	*ZIP Code:	Telephone: ( ) -

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

SIGNATURE OF EMPLOYEE/MEMBER _____ **DATE**_____/_____/_____

CMH/GHS RETIREE OPTIONS

2022 Retiree Healthcare Enrollment Drives Options Available to Spouse

IMPORTANT - Please read carefully! As a Retiree from CMH/GHS, you are the reason and the *pathway* for your potentially eligible spouse and/or child(ren) to enroll in a GHS sponsored healthcare plan. The selection of a healthcare plan made by the Retiree *drives the options* an eligible spouse/child might be enrolled into. What follows are several examples of healthcare enrollment decisions a Retiree might make and the corresponding result of that decision for their spouse/child as potential enrollees via GHS sponsored plans:

Please Note that HAP Medicare Advantage plans only provide coverage (other than emergency services) in Michigan.

Retiree Under 65 Non-Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects ***HAP HDHP HMO**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects ****HAP HDHP PPO***, spouse may only enroll in ***HAP HDHP PPO*** version

Both under 65 Non-Medicare; Must be enrolled into the **same** Health Alliance Plan

Retiree Under 65 Non-Medicare Eligible; w/ Spouse 65+ Medicare Eligible

- Retiree elects **HAP HDHP HMO**, spouse may only enroll in **HAP MA HMO** version or ***BC-MA**
- Retiree elects **HAP HDHP PPO**, spouse may only enroll in **HAP MA PPO** version or **BC-MA**

Retiree Over 65 Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects **HAP MA HMO or BC-MA**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects **HAP MA PPO or BC-MA**, spouse may only enroll in **HAP HDHP PPO** version

Retiree Over 65 Medicare Eligible; w/ Spouse Over 65 Medicare Eligible

- Retiree elects **HAP MA HMO**, spouse may only enroll in **HAP MA HMO** version
- Retiree elects **HAP MA PPO**, spouse may only enroll in **HAP MA PPO** version
- Retiree elects **BC-MA**, spouse may only enroll in **BC-MA**

Both Medicare Eligible (Retiree and Spouse); Must be enrolled into the **same** plan design selected by the retiree

If you have any questions or concerns, you may contact:
Tami Plantz (tplantz@genhs.org) or phone (810) 496-5603
Sandy Sweet (**ssweet@genhs.org**) or phone (810) 496-5759 or fax (810) 496-5755

*Health Alliance Plan High Deductible Health Plan HMO
**Health Alliance Plan High Deductible Health Plan PPO
***Blue Cross Blue Shield Medicare Plus Blue Group

HEALTHCARE ENROLLMENT CHECKLIST
Medicare Eligible Retirees

If you are making no changes to healthcare:

- ☐ Review your prefilled GHS Enrollment Form. If it is correct, sign, date and return.
- ☐ Sign and return the No Dual Hospital/Medical Coverage Certification
- ☐ Complete and return the Mutual of Omaha Beneficiary Form

STOP HERE: Please mail your documents in the self-addressed, stamped envelope.

If you are <u>new to Medicare Advantage</u>, complete the following:

- ☐ Complete the enclosed, blank GHS Enrollment Form in its entirety
- ☐ Complete the appropriate Medicare Advantage Enrollment Application (available on retiree website)

Attach a copy of the applicable items listed below:

- ☐ Medicare Card(s), applicable to you or any family member **if 1st time enrollee; or selecting new plan**
- ☐ "No Dual Hospital/Medical Coverage Certification" form – Signed
- ☐ Completed Mutual of Omaha Beneficiary Form
- ☐ Marriage Certificate
- ☐ Birth Certificates & Social Security cards of dependents

If you are changing your Medicare Advantage Plan:

Complete all of the items listed above that are applicable as well as

- ☐ Appropriate Disenrollment Form (available on retiree website)

Please return all required documentation by **Monday, November 22, 2021** in the self-addressed, stamped envelope. Thank you.

Sandra Sweet
Accounting Manager
Genesee Health System
420 W. Fifth Avenue, Flint, MI 48503
Phone 810.496.5759 Fax 810.496.5755

Tami Plantz
Accountant
Genesee Health System
420 W. Fifth Avenue, Flint, MI 48503
Phone 810.496.5603 Fax 810-496-5755

Medicare Advantage

2022 Plan Comparisons

*** Review the Full Plan Summaries on the Retiree Website**

	BC Medicare Advantage Plus Blue Group BC-MA	HAP Medicare Advantage HMO HAP MA HMO	HAP Medicare Advantage PPO HAP MA PPO
COMMENTS	**No Incentives**	**No Incentives**	**No Incentives**
Benefits		**In-network**	**In-network**
Deductible	Annual Deductible $100	$0	$0
Out of Pocket Max (Based upon In-Network)	$1,000 for Services Received in-network, $2,000 for Services received out of network. (Exceptions) Prescriptions are not included in the Out of Pocket Max.	**$3,400** Does Not Include Prescription Drugs	**$3,400** Does Not Include Prescription Drugs
Inpatient Hospital	5% after Deductible up to $1,000 max/year	$250 per stay	$0 Copay
Skilled Nursing Facility	$0 Copay (Covered up to 120 days per benefit period. Renew once out of hospital or skilled nursing facility 60 days in a row.)	$0 Copay (100 day annual limit)	$0 Copay (100 day annual limit)
Emergency Care	$50 Copay	$65 Copay (Waived if Admitted)	$50 Copay (Waived if Admitted)
Urgent Care	$15 Copay	$45 Copay	$15 Copay
Primary Physician Services	$15 Copay per visit	$15 Copay	$10 Copay
Specialist Services	$15 Copay per visit	$35 Copay (Referral required)	$10 Copay (Referral required)
Chiropractic Services	$15 Copay	$20 Copay (Referral required)	$20 Copay (Referral required)
Diagnostic Tests, X-rays, Lab Services	5% after Deductible up to $1,000 max/year	$0 Copay	$0 Copay
Hearing Exams - Medicare Covered	$15 Copay; 5% coinsurance for Diagnostic Testing/up to $1500 limit Hearing Aids every 36 months.	$35 Copay	$10 Copay
Preventive Dental	N/A	N/A	N/A
Non Medical Vision Services	N/A	$35 Copay/Eye Exam Every 12 Months	$10 Copay/Eye Exam Every 12 Months
Rx: Generic 30-Day/90-Day Supply	Preferred Generic $10/$30 Generic $10/$30 Copay ***For Preferred Pharmacy Pricing See Benefits-at-a-Glance***	Preferred & Non-Preferred Generic $10/$25 Copay	Preferred Generic $10/$20 Non-Preferred Generic $15/$30
Rx: Preferred Brand 30-Day/90-Day Supply	$40/$120 Copay ***For Preferred Pharmacy Pricing See Benefits-at-a-Glance***	$35/$87.50 Copay	$20/$40 Copay
Rx: Non-Preferred Brand 30-Day/90-Day Supply	$40/$120 Copay ***For Preferred Pharmacy Pricing See Benefits-at-a-Glance***	$50/$125 Copay	$45/$90 Copay
Rx: Specialty Drugs	$40 Copay 30 day Supply ***For Preferred Pharmacy Pricing See Benefits-at-a-Glance***	$50 Copay	32% of cost
Rx: Catastrophic Drug Coverage Stage	After reaching $7,050 in Rx, Catastrophic Limit, then greater of $3.95 or 5% for generic and $9.85 or 5% for all others	After reaching $6,350 in Rx, Catastrophic Limit, then greater of $3.60 or 5% for generic and $8.95 or 5% for all others	After reaching $6,350 in Rx, Catastrophic Limit, then greater of $3.60 or 5% for generic and $8.95 or 5% for all others
Comments	**National Network**	**MI ONLY**	**In Network MI ONLY**

Enrollment request for Genesee Health System

51150-601

<BCBSM ID #>

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact <Medicare Plus Blue Group PPO> if you need information in another language or format.

Please provide the following information. Please print.				
☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name			
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number	
Permanent residence street address (*cannot be a post office box*)			City	State
ZIP code	County	Email address (optional)		
Mailing address (*if different from your permanent residence address*)				
Street address	City	State	ZIP code	
Optional information				
Emergency contact name				
Relationship to you	Telephone number			

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

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-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) 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.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 4 to send your completed form to the plan.

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance,workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: _____ Name of other drug plan: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**
6. (Optional)**Please enter the name of your primary doctor:** _____	**Primary doctor's telephone:**

This enrollment application is part of your <Medicare Plus Blue Group PPO> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact <Medicare Plus Blue Group PPO> Customer Service at <**1-866-684-8216**> (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.
<£ Spanish £ Other>

Select one if you want us to send you information in an accessible format.
☐ Large print £ Audio CD

Customer Service hours are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Important: Please read and sign below.

By completing this enrollment application, I agree to the following:

<Medicare Plus Blue Group PPO> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available, or under certain special circumstances. As a Medicare Advantage PPO member, <Medicare Plus Blue Group PPO> works differently than a Medicare supplemental plan. <Medicare Plus Blue Group PPO> pays instead of Medicare, and I will be responsible for the amounts that <Medicare Plus Blue Group PPO> does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in <Medicare Plus Blue Group PPO>.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater. Out-of-Network/non-contracted providers are under no obligation to treat <Medicare Plus Blue Group PPO> members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

<Medicare Plus Blue Group PPO> serves a specific service area. If I move out of the area that <Medicare Plus Blue Group PPO> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Medicare Plus Blue Group PPO>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverag*e document from <Medicare Plus Blue Group PPO> when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with <Medicare Plus Blue Group PPO>, he/she may be paid based on my enrollment in <Medicare Plus Blue Group PPO>.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the <Medicare Plus Blue Group PPO> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Medicare Plus Blue Group PPO> who will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by <Medicare Plus Blue Group PPO> or by Medicare.

Please sign below. **By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.**			
Signature:		Today's date:	
If you are the authorized representative, you must sign above and provide the following information:			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Medicare Plus Blue Group PPO
P.O. Box 44256
Detroit, Michigan 48244-0256

OR

Fax to: 1-866-533-5810

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Alliance Health and Life Insurance Company
Alliance Medicare PPO (MAPD)
Genesee Health System - PPO NETWORK (MA)

MA000203 / XS000136 QR-35124

Health Care Services	In-Network Coverage	Out-of -Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible	None	None	
Co-insurance (amount enrollee pays)	None	20%	
Annual Co-insurance Maximum	N/A	N/A	
Maximum-Out-of-Pocket Cost **	$3,400	$6,800 (Combined In-Network and Out-of-Network)	These values do not accumulate: Premiums, balance-billed charges, Part D drugs, and health care this plan does not cover. All other cost sharing applies.
Medicare-Covered Preventive Services (partial list):			
Annual Wellness Visit	Covered	Plan Pays 80%	
Immunizations	Covered	Plan Pays 80%	
Related Laboratory and Radiology Services	Covered	Plan Pays 80%	
Pap Smears and Mammograms	Covered	Plan Pays 80%	
Outpatient & Physician Services:			
Personal Care Physician Office Visit	$10 Copay	Plan Pays 80%	
Specialty Physician Office Visit	$10 Copay	Plan Pays 80%	
Gynecology Office Visit	$10 Copay	Plan Pays 80%	
Audiology Office Visit	$10 Copay	Plan Pays 80%	
Routine Eye Examination Office Visit	$10 Copay	Plan Pays 80%	Through our contracted provider EyeMed only.
Medical Eye Examination Office Visit	$10 Copay	Plan Pays 80%	
Allergy Treatment and Injections	Covered	Plan Pays 80%	
Diagnostic Laboratory & Pathology	Covered	Plan Pays 80%	
Radiology (X-ray)	Covered	Plan Pays 80%	
Dialysis	Covered	Plan Pays 80%	
Chemotherapy	Covered	Plan Pays 80%	
Radiation Therapy	Covered	Plan Pays 80%	
Outpatient Surgery	Covered	Plan Pays 80%	
Chiropractic Services	$20 Copay	Plan Pays 80%	Manipulation of the spine for subluxation only
Emergency/Urgent Care:			
Emergency Room Services	$50 Copay		Copay will be waived if admitted
Urgent Care Facility Services	$15 Copay		
Emergency Ambulance Services	Covered		Emergency transport only

Alliance Health and Life Insurance Company
Alliance Medicare PPO (MAPD)
Genesee Health System - PPO NETWORK (MA)

MA000203 / XS000136 QR-35124

Health Care Services	In-Network Coverage	Out-of -Network Coverage	Limitations
Inpatient Hospital Services: * * **			
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	Plan Pays 80%	
Mental/Behavioral Health:			
Inpatient Services * ***	Covered	Plan Pays 80%	
Outpatient Services	$10 Copay	Plan Pays 80%	Covered according to Medicare guidelines
Substance Use Disorder:			
Inpatient Services * ***	Covered	Plan Pays 80%	Covered according to Medicare guidelines
Outpatient Services	$10 Copay	Plan Pays 80%	Covered according to Medicare guidelines
Other Services:			
Home Health Care	Covered	Plan Pays 80%	
Hospice Care	You must get care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not Alliance Medicare PPO.		
Skilled Nursing Care	Covered	Plan Pays 80%	(Combined In-Network and Out-of-Network). Up to 100 days per benefit period . Hosptial stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	Covered	Plan Pays 80%	Coverage provided for approved equipment based on Medicare guidelines
Vision Hardware	Covered	Plan Pays 80%	(Combined In-Network and Out-of-Network). Corrective eyeglasses and/or contact lenses are covered once every 12 month period when prescribed by and purchased from an EyeMed-Participating ophthalmologist or optometrist with a $100 combined benefit maximum. See EOC for benefits relating to cataract surgery.
Physical and Speech Therapy (PT/ST)	Covered	Plan Pays 80%	Covered according to Medicare guidelines. In-Network & Out-of-Network
Occupational Therapy (OT)	Covered	Plan Pays 80%	Covered according to Medicare guidelines. In-Network & Out-of-Network
Pharmacy:			
Tier 1: Preferred Generic - $10 Copay Tier 2: Non-Preferred Generic - $15 Copay Tier 3: Preferred Brand - $20 Copay Tier 4: Non-Preferred Brand - $45 Copay Tier 5: Specialty Drugs - 32% Tier 6: Select Care Drugs - $0 Copay	Covered (HAP network includes pharmacies with nationwide locations)	See EOC for certain situations	Gap Coverage **'Retail/Mail**: 30 day supply for Part D drugs for 1 copay for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand Drugs; 90 day supply of Part D drugs available for 2 times the 30 day copay for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand Drugs. Tier 5 and 6 drugs are only available at 30-day supply.

Riders: M000, M045,XP401,XP405,XP482,XP418,XP430,XP437,XP455,XP481,XP593,M673

* Please report hospital admissions within 48 hours at 313-664-8833 or 1-800-288-5959.
** Limit on the total of copays or co-insurance you might pay during the benefit period.
*** Inpatient deductible cumulative - i.e., medical, mental health and behavioral medicine; copay / day based on consecutive days in hospital not cumulative across separate admissions.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. In cases of conflict between this summary and your Evidence of Coverage, the terms and conditions of the Evidence of Coverage govern.

Alliance Medicare PPO is a health plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

Senior Plus (HMO)

HMO

Medicare Advantage HMO
Employer/Union Group Health Plan
Enrollment Request Form

Health Alliance Plan
2850 W. Grand Blvd., Detroit, MI 48202
Telephone (800) 868-3153
TTY: 711

Please contact HAP Senior Plus (HMO) if you need information in another language or format (large print).

To enroll in HAP Senior Plus (HMO), Please Provide the Following Information

Employer or Union Name:	Group Number (If known. If not leave blank):

LAST Name:	FIRST Name:	Middle Initial	❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date:	Sex:	Home Phone Number:
(___ ___/___ ___/___ ___ ___ ___)	❑ M ❑ F	( ) _____
M M/D D / Y Y Y Y		Email:

Permanent Residence Street Address (P.O. Box is not allowed): _____

City: _____ State: _____ ZIP Code: _____ County:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ **Relationship to You:** _____

Phone Number: _____

Please Provide Your Medicare Insurance Information

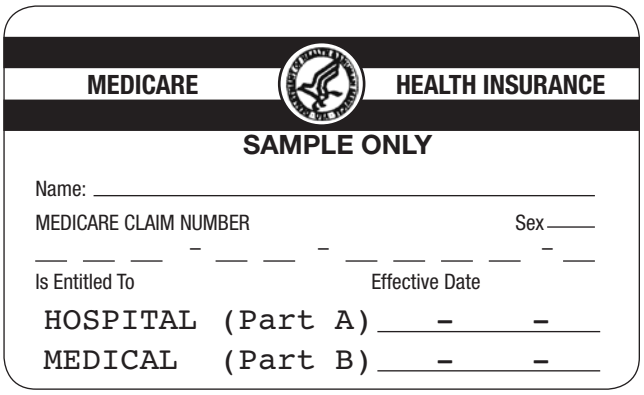
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



Please read and answer these important questions:

1. Are you the retiree? . . . . . ❑ Yes ❑ No

   If yes, retirement date (month/date/year): _____

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? . . . . . ❑ Yes ❑ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? . . . . . ❑ Yes ❑ No

4. Do you have End Stage Renal Disease (ESRD)? . . . . . ❑ Yes ❑ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensative, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to HAP Senior Plus? . . . . . ❑ Yes ❑ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage:_____ Group # for this coverage_____

6. Are you a resident in a long-term care facility, such as a nursing home? . . . . . ❑ Yes ❑ No

   If "yes", please provide the following information:

   Name of Institution: _____

   Address & Phone Number of Institution (number and street): _____

   _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Medical Center Name: _____

Primary Care Physician Name: _____

Primary Care Physician ID #: _____

Please check one of the boxes below if you would prefer us to send you information in another format:

❑ Large print

❑ Audio tape

Please contact HAP Senior Plus at (800) 868-3153, if you need information in another format than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD users should call TTY: 711.

Please Read and Sign Next Page

By completing this enrollment application, I agree to the following:

HAP Senior Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of HAP Senior Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HAP Senior Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HAP Senior Plus, he/she may be paid based on my enrollment in HAP Senior Plus.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare heath plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____ **)** ____ **-** _____

Relationship to Enrollee: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _ AEP: ____ SEP (type): Not Eligible: _____

Health Alliance Plan of Michigan
HAP Senior Plus HMO
GENESEE HEALTH SYSTEM - FULL HMO NETWORK (MAPD)

MA000200 / XS000144 QR-35123

Health Care Services	In-Network Coverage	Limitations
Benefit Period, Annual Deductible, and Annual Co-insurance Maximums:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	None	
Maximum-Out-of-Pocket Cost**	$3,400 Individual	These values do not accumulate: Premiums, balance-billed charges, Part D pharmacy liabilities, and health care this plan doesn't cover. All other cost sharing applies.
Medicare-Covered Preventive Services (partial list):		
Annual Wellness Visit	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$15 Copay	
Specialty Physician Office Visit	$35 Copay	
Gynecology Office Visit	$35 Copay	
Audiology Office Visit	$35 Copay	
Routine Eye Examination Office Visit	$35 Copay	Through our contracted provider Eyemed only.
Medical Eye Examination Office Visit	$35 Copay	
Allergy Treatment and Injections	Covered	
Diagnostic Laboratory & Pathology	Covered	
Radiology (X-ray)	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	$150 Copay	
Chiropractic Services	$20 Copay	Manipulation of the spine for subluxation only

Health Alliance Plan of Michigan
HAP Senior Plus HMO
GENESEE HEALTH SYSTEM - FULL HMO NETWORK (MAPD)

MA000200 / XS000144 QR-35123

Health Care Services	In-Network Coverage	Limitations
Emergency/Urgent Care:		
Emergency Room Services	$65 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$45 Copay	
Emergency Ambulance Services	$50 Copay	
Inpatient Hospital Services: *		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	$250 Admission Copay	
Mental/Behavioral Health:		
Inpatient Services *	$250 Admission Copay	Covered for 190 days per lifetime according to Medicare guidelines, then covered for 30 days renewable after 60 days.
Outpatient Services	$15 Copay	Unlimited
Substance Use Disorder:		
Inpatient Services *	$250 Admission Copay	Unlimited
Outpatient Services	$15 Copay	Unlimited
Other Services:		
Home Health Care	Covered	
Hospice Care	You must get care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not HAP Senior Plus.	
Skilled Nursing Care	Covered	Up to 100 days per benefit period. Hosptial stay not required. Authorization rules apply.
Durable Medical Equipment; Prosthetics & Orthotics	Plan pays 80%	Coverage provided for approved equipment based on Medicare guidelines.
Vision Hardware	Not Covered	See Evidence of Coverage (EOC) for benefits relating to cataract surgery.
Physical, and Speech Therapy (PT/ST)	Covered	Medicare guidelines and authorization rules apply.
Occupational Therapy (OT)	Covered	Medicare guidelines and authorization rules apply.
Pharmacy:		
Tier 1: Preferred Generic drugs - $10 Copay Tier 2: Non-Preferred Generic drugs - $10 Copay Tier 3: Preferred Brand drugs - $35 Copay Tier 4: Non-Preferred Brand drugs - $50 Copay Tier 5: Specialty drugs - $50 Copay Tier 6: Select Care drugs - $0 Copay	Covered	Coverage in the Gap Retail/Mail Order: 30 day supply of Part D drugs for 1 copay. 60 day supply for 2 times the 30 day copay. 90 day supply of Part D drugs for 2 1/2 times the 30 day copay. Tier 5 and 6 drugs are only available for 30-day supply.

Riders: S095, X401, X405, X419, X423, X430 , X431, X444, X489, X492, X493, X594, X558, S697

* Please contact HAP if you are admitted to the hospital.
**Limit on the total of copays or co-insurance you might pay during the benefit period.
The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. In cases of conflict between this summary and your Evidence of Coverage, the terms and conditions of the Evidence of Coverage govern.

Health Alliance Plan is a health plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

Senior Plus (PPO)
Alliance Health and Life Insurance Company

PPO

Medicare Advantage PPO
Employer/Union Group Health Plan
Enrollment Request Form

Health Alliance Plan
2850 W. Grand Blvd., Detroit, MI 48202
Telephone (800) 868-3153
TTY: 711

Please contact HAP Senior Plus (PPO) if you need information in another language or format (large print).

To enroll in HAP Senior Plus (PPO), Please Provide the Following Information

Employer or Union Name:	Group Number (If known. If not leave blank):

LAST Name:	FIRST Name:	Middle Initial	❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date:	Sex:	Home Phone Number:
(___ ___/___ ___/___ ___ ___ ___)	❑ M ❑ F	( ) _____
M M/D D/Y Y Y Y		Email:

Permanent Residence Street Address (P.O. Box is not allowed): _____

City: _____ State: _____ ZIP Code: _____ County: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ **Relationship to You:** _____

Phone Number: _____

Please Provide Your Medicare Insurance Information

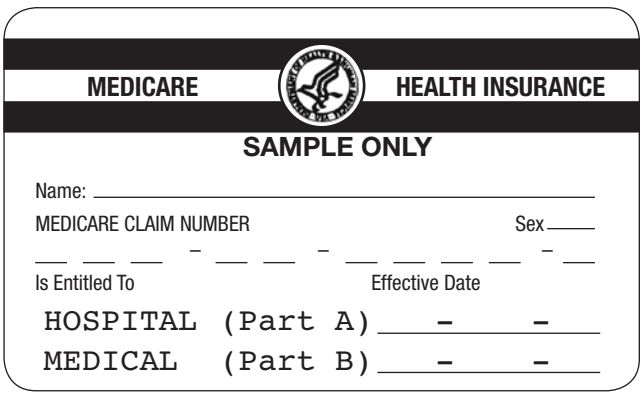
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



Please read and answer these important questions:

1. Are you the retiree? . . . . . ❑ Yes ❑ No

   If yes, retirement date (month/date/year): _____

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? . . . . . ❑ Yes ❑ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? . . . . . ❑ Yes ❑ No

4. Do you have End Stage Renal Disease (ESRD)? . . . . . ❑ Yes ❑ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensative, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to HAP Senior Plus? . . . . . ❑ Yes ❑ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage:_____ Group # for this coverage_____

6. Are you a resident in a long-term care facility, such as a nursing home? . . . . . ❑ Yes ❑ No

   If "yes", please provide the following information:

   Name of Institution: _____

   Address & Phone Number of Institution (number and street): _____

   _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Medical Center Name: _____

Primary Care Physician Name: _____

Primary Care Physician ID #: _____

Please check one of the boxes below if you would prefer us to send you information in another format:

❑ Large print

❑ Audio tape

Please contact HAP Senior Plus at (800) 868-3153, if you need information in another format than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD users should call TTY: 711.

Please Read and Sign Next Page

By completing this enrollment application, I agree to the following:

HAP Senior Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of HAP Senior Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HAP Senior Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HAP Senior Plus, he/she may be paid based on my enrollment in HAP Senior Plus.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare heath plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____ **)** ____ **-** _____

Relationship to Enrollee: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _ AEP: ____ SEP (type): Not Eligible: _____

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

GENESEE HEALTH SYSTEM
0070003700021 - 05CRY
Effective Date: 01/01/2021

Vision Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	

ADM PLANYR JAN;BLUE VISION;BVFLE;BVPP CHOICE NET

Benefits	VSP network doctor	Non-VSP provider
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $10 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 24 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 24 **consecutive** months	

Medicare PLUS Blue Group PPO℠

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

EMPLOYER/UNION GROUP HEALTH PLAN DISENROLLMENT REQUEST FORM

	Group Initiated Disenrollment Request (Involuntary Disenrollment)

This request is for a ***group- initiated*** member disenrollment. The group has determined that this member no longer meets the group's eligibility criteria. The member will be given 21 days prospective notice prior to being disenrolled after receipt by BCBSM if the request is involuntary.

If this disenrollment request is due to a member's death, the effective date of this disenrollment will be the last day of the month in which the member dies. BCBSM must wait for CMS acknowledgement of the member's death to formally terminate the member**.**

Please provide reason for disenrolling:

X	Group Initiated Disenrollment Request (Voluntary Disenrollment)

This request is for a ***voluntary*** member disenrollment. This request will be effective the last day of the month in which the request is received by BCBSM.

If the group has a disenrollment request signed by the member it should be attached to this form.

Please provide reason for disenrolling:

OTHER COVERAGE

To Disenroll a Medicare Plus Blue Group member, provide the following information:

MA Contract Number	Last Name	First name	Date of Birth	Medicare Number
			/ /	

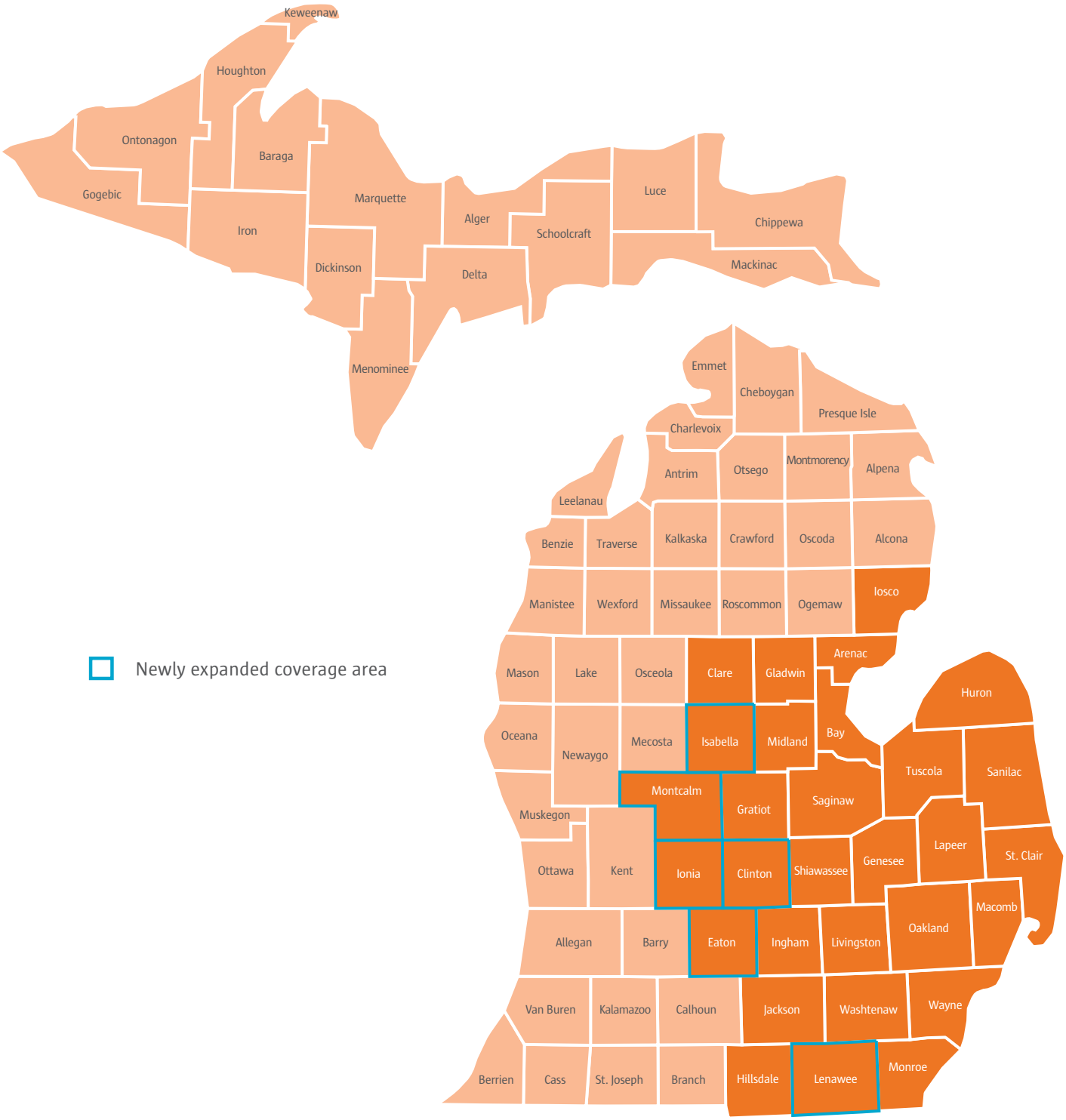
Group Name: **GENESEE HEALTH SYSTEM**	**Effective Date of Change:**
Group Requestor Name and Title: **SANDY SWEET/ACCOUNTANT**	**Today's Date:**

Please return to: Medicare Plus Blue Group PPO
P O Box 44256
Detroit, MI 48244-0256

or

Fax to # (866) 562-2421

HAP Senior Plus Medicare Service Area



Newly expanded coverage area