Genesee HEALTH SYSTEM
Hope and health in the community

MAIN CAMPUS
1040 W. Bristol Road
Flint, MI 48507
Phone: (810) 257-3740
www.genhs.org

October 19, 2026

RE: Non-Medicare Retiree Options

Retiree Open Enrollment is under way 11/16/2026 through 11/30/2026.

Retirees who do not need to make changes: For the 2027 Plan Year, GHS will not require retirees to complete the annual open enrollment packet unless making a change to a medical, dental or vision plan**. If there are no changes, nothing is required of you.**

Retirees who need to make changes: Open Enrollment information and other reference documents are listed on the GHS website at www.genhs.org - CMH/GHS Retirees tab near the bottom of the page. **If you need enrollment assistance, you may reach out to Benefits by email (benefits@genhs.org) or phone (810) 496-5561.**

Please note, GHS will continue to offer the Health Alliance Plan (HAP) High Deductible Health Plan HMO (HAP HDHP HMO) and Health Alliance Plan High Deductible Health Plan PPO (HAP HDHP PPO) for the 2027 enrollment year. **Deductibles for the 2027 enrollment year are $1750 for a single, and $3500 for a double or family.** Dental and Vision coverage options remain the same as in 2026.

If you or your spouse will be eligible for Medicare in 2027, Benefits will reach out to you at the appropriate time and assist you with the change in enrollment.

Please keep in mind that the **Open Enrollment period is 11/16/2026 thru 11/30/2026.** If you need to make changes, please do so on or before **November 30, 2026.** We have provided additional information on the GHS retiree website which you may find informative and beneficial, in addition to enrollment forms and other reference documents. Dental and Vision coverage options remain the same as in 2026. As a final reminder, if you will be eligible for an HSA contribution, your HSA account must be open and active.

Please direct any questions or concerns, to **benefits@genhs.org, or reach out directly at (810) 496-5561**.

Sincerely,

Erica Smith

Erica Smith, Compensation & Benefits Manager
Genesee Health System

GENESEE HEALTH SYSTEM

Retiree Under 65– Retired Prior to 11/20/2007

2027 INSURANCE ENROLLMENT

Enrollment/Change Status: Open Enrollment ☐ Other Period ☐

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

MEDICAL INSURANCE OPTIONS ***HAP=Health Alliance Plan***	**Single**	**Two-Party**	**Family**	Effective Date:	GHS Initials
*HAP High Deductible Health Plan (PPO)	☐	☐	☐	(For Official Use Only)	
*HAP High Deductible Health Plan (HMO) (**Base Plan** is HMO version)	☐	☐	☐		
OPTICAL/DENTAL INSURANCE					
Blue Cross Blue Shield of Michigan	☐	☐	☐	Effective Date:	GHS Initials:
Delta Dental of Michigan	☐	☐	☐	Effective Date:	GHS Initials

CONTRACT CONTINUATION □ ***ADDITION*** □ ***DELETION*** □

Last Name (Print)	**First Name**	**Relation**	**F/M**	**SSN**	**DOB**	**Primary Care Physician**
		SELF				
		SPOUSE				
		DEPEND				
		DEPEND				

Please Note: Initial spouse and dependent coverage is subject to verification of eligibility. Eligibility documents include a copy of marriage license and social security card for spouse; and birth certificate and social security card for dependent. Provisions and penalties described in the "No Dual Hospital/Medical Coverage Certification" form apply. Please see the CMH/GHS Retiree Options document included in the packet for further explanation of insurance selections.

I certify that I have read and understand the 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 health care contract void and refuse all allowance of the benefits to any person under the contract. I understand that anyone listed above, seeking enrollment into a GHS sponsored health plan is prohibited from being enrolled in any other hospital/medical coverage, including Medicare.

Please contact benefits at benefits@genhs.org or (810) 496-5561 for questions.

Retiree's 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 GHS benefits personnel 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 GHS benefits personnel 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 GHS benefits personnel 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.

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

2027 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 contract:
Benefits (benefits@genhs.org) or phone (810) 496-5561 or fax (810) 496-5767

*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 Options

Under "65" Retirees

Retired Prior to 11/20/2007

January 1, 2027 - December 31, 2027

Benefit	HAP HDHP PPO	HAP HDHP HMO
Deductible	$1,750 Single/$3,500 Double, Family (Agency to fund into HSA Account $1,350 Single; or $2,500 Family)	$1,750 Single/$3,500 Double, Family (Agency to fund into HSA Account $1,350 Single; or $2,500 Family)
Co-insurance (after deductible is met)	$1,000 per single or $2,000 per family	$1,000 per single or $1,000 per family (Agency to Reimburse 80% of Expenses)
Prescription Co-pay	$10 Generic / $50 Brand (After Deductible is met)	$10 Generic / $50 Brand (After Deductible is met)
Office Co-pay	$25 co-pay (After Deductible is met)	$15 co-pay (After Deductible is met)
Comments Questions? Please call 810-496-5561		Must reside in Michigan and receive Primary Care services in the 20 county service area.

HEALTHCARE ENROLLMENT CHECKLIST
Non Medicare Retiree-Retired Prior to 11/20/2007

Please note the following deductibles apply to the HAP HD HMO and PPO Plans: Individual Plan/$1,750 Family Plan/$3,500

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 changing your healthcare plan:

- ☐ Complete the enclosed, blank GHS Enrollment Form in its entirety (available on the GHS Retiree website)

  Attach a copy of the applicable items listed below:

  - ☐ "No Dual Hospital/Medical Coverage Certification" form – Signed
  - ☐ Completed Mutual of Omaha Beneficiary Form
  - ☐ Marriage Certificate
  - ☐ Birth Certificates & Social Security cards of dependents

Please return all required documentation by **Monday, November 30, 2026** in the self-addressed, stamped envelope. Thank you.

Benefits
Genesee Health System
1040 W. Bristol Road, Flint, MI 48507
Phone 810.496-5561 Fax 810.496.5767

Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company
Self-Funded Health Maintenance Organization (HMO) Plan
Summary of Benefits
ASO HMO Custom 7014 / Rx ASO HMO Custom 7014

Self-Funded HMO

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,750 Self Only; $3,500 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	Deductible does not include Copays or Coinsurance. Deductible applies to the Annual Out-of-Pocket Limit.
Coinsurance	10%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Limit.
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Limit	$2,700 Self Only; $4,300 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	These values do not accumulate: Premiums, Balance-Billed charges, and health care this plan doesn't cover. All other Cost Sharing accumulates unless otherwise specified.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$15 Copay after Deductible	N/A	
HAP Telehealth	$15 Copay after Deductible	N/A	Through our Designated Telehealth Partner.
Specialist Office Visit	$15 Copay after Deductible	N/A	
Routine Hearing Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	10% Coinsurance after Deductible	N/A	Up to 10 visits per Benefit Period.
Allergy Treatment	10% Coinsurance after Deductible	N/A	
Allergy Injections	10% Coinsurance after Deductible	N/A	
Laboratory & Pathology	10% Coinsurance after Deductible	N/A	Some services require Prior Authorization.
Imaging MRI, CT & PET Scans	10% Coinsurance after Deductible	N/A	Services require Prior Authorization.
Radiology (X-ray)	10% Coinsurance after Deductible	N/A	Some services require Prior Authorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after Deductible	N/A	
Dialysis	10% Coinsurance after Deductible	N/A	
Outpatient Medical Drugs	10% Coinsurance after Deductible	N/A	
Outpatient Hospital & Ambulatory Surgical Center Services			
Outpatient Hospital Surgical Facility	10% Coinsurance after Deductible	N/A	
Ambulatory Surgical Center	10% Coinsurance after Deductible	N/A	
Professional Surgical and Related Services	10% Coinsurance after Deductible	N/A	
Emergency & Urgent Care			
Urgent Care	$50 Copay after Deductible		
Emergency Room Care	$100 Copay after Deductible		Emergency Room Care Copay is waived if admitted.
Emergency Medical Transportation	10% Coinsurance after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after Deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after Deductible	N/A	
Bariatric Surgery and Related Services	10% Coinsurance after Deductible	N/A	One procedure per lifetime
Maternity Care Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder Services			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$15 Copay after Deductible	N/A	
Other Services			
Home Health Care	10% Coinsurance after Deductible	N/A	Does not include Rehabilitation Services. Up to 60 visits per Benefit Period.
Hospice Care	10% Coinsurance after Deductible	N/A	Up to 210 days per lifetime
Skilled Nursing Facility Services	10% Coinsurance after Deductible	N/A	Services require Prior Authorization. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after Deductible	N/A	Some equipment/supplies require Prior Authorization.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after Deductible	N/A	May be provided at home. Some services require Prior Authorization. Up to 60 combined visits per Benefit Period.
Habilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after Deductible	N/A	Limited to treatment of Autism Spectrum Disorder. Habilitation Services for conditions other than Autism Spectrum Disorder follow the Rehabilitation Services benefit, including its Cost-Sharing and visit limits. Services require Prior Authorization.
Applied Behavioral Analysis	$15 Copay after Deductible	N/A	Limited to treatment of Autism Spectrum Disorders. Services require Prior Authorization.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy. See Preventive Services for tubal ligation.
Voluntary Term of Pregnancy	See Outpatient Surgical Services	N/A	During first trimester only. Limited to 1 within a 24 month period.
Infertility Services	50% Coinsurance after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Services require Prior Authorization.
Assisted Reproductive Technologies	50% Coinsurance after Deductible	N/A	One attempt per lifetime
Temporomandibular Joint Disorder Treatment	10% Coinsurance after Deductible	N/A	Coverage is limited to non-surgical treatments.
Outpatient Prescription Drugs (Affiliated Pharmacy Providers only)			
Tier 1	$10 Copay 30 - day supply, $20 Copay 90 - day supply after Deductible		Tier 5 and 6 drugs are restricted to up to a 30-day supply per fill. In rare cases, an exception applies and a larger supply may be approved. If a Copay or Maximum applies, you will pay double the amount for a 31-60-day supply and triple the amount for a 61-90-day supply.
Tier 2	$10 Copay 30 - day supply, $20 Copay 90 - day supply after Deductible		
Tier 3	$50 Copay 30 - day supply, $100 Copay 90 - day supply after Deductible		
Tier 4	$50 Copay 30 - day supply, $100 Copay 90 - day supply after Deductible		
Tier 5	$50 Copay 30 - day supply at specialty pharmacy only after Deductible		
Tier 6	$50 Copay 30 - day supply at specialty pharmacy only after Deductible		
Infertility Drugs	50% Coinsurance after Deductible		

QHDHP

- Self-funded HMO plans are administered by Alliance Health and Life Insurance Company (Alliance), a wholly owned subsidiary of Health Alliance Plan.
- This document provides a general overview of your benefits. It is not a contract or legal document. If there is a conflict between this document and the terms and conditions of your Benefit Guide, the terms and conditions of your Benefit Guide, the Schedule of Benefits and any attached Riders will apply.
- You must notify Alliance prior to an elective hospital admission. Alliance must be notified within 48 hours after any emergency hospital admission. If Alliance is not notified, your benefits may be reduced or denied.
- Alliance's HMO plans include the Students Away at School Program.
- Some services require Prior Authorization. Failure to obtain Prior Authorization before receiving services could result in a reduction or denial of benefits.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company
Self-Funded Preferred Provider Organization (PPO)
Summary of Benefits
ASO PPO Custom 7015 / Rx ASO PPO Custom 7015

Self-Funded PPO

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,750 Self Only; $3,500 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	$2,600 Individual; $5,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	Deductible does not include Copays or Coinsurance. In and Out-of-Network Deductibles accumulate separately. Deductible applies to the Annual Out-of-Pocket Limit.
Coinsurance	10%	30%	Coinsurance applies towards the Annual Out-of-Pocket Limit.
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Limit	$2,700 Self Only; $5,300 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	$3,600 Self Only; $7,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	These values do not accumulate: Premiums, Balance-Billed charges, and health care this plan doesn't cover. All other Cost Sharing accumulates unless otherwise specified. In and Out-of-Network Out-of-Pocket Limits accumulate separately.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay after Deductible	30% Coinsurance after Deductible	
HAP Telehealth	$25 Copay after Deductible	Not Covered	Through our Designated Telehealth Partner.
Specialist Office Visit	$25 Copay after Deductible	30% Coinsurance after Deductible	
Routine Hearing Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$25 Copay after Deductible	30% Coinsurance after Deductible	Up to 38 visits per Benefit Period. (Combined In and Out-of-Network)
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Allergy Injections	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Laboratory & Pathology	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Some services require Prior Authorization.
Imaging MRI, CT & PET Scans	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Services require Prior Authorization.
Radiology (X-ray)	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Some services require Prior Authorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Dialysis	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Outpatient Medical Drugs	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Outpatient Hospital & Ambulatory Surgical Center Services			
Outpatient Hospital Surgical Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Ambulatory Surgical Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Professional Surgical and Related Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Emergency & Urgent Care			
Urgent Care	10% Coinsurance after Deductible		
Emergency Room Care	10% Coinsurance after Deductible		
Emergency Medical Transportation	10% Coinsurance after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Bariatric Surgery and Related Services	Not Covered	Not Covered	
Maternity Care Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	30% Coinsurance after Deductible	In-Network covered under Preventive Services. For non-routine visits, see Specialist Office Visit
Routine Postnatal Office Visits	Covered - Deductible does not apply	30% Coinsurance after Deductible	In-Network covered under Preventive Services. For non-routine visits, see Specialist Office Visit
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	

Mental Health & Substance Use Disorder Services			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	$25 Copay after Deductible	30% Coinsurance after Deductible	
Other Services			
Home Health Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Does not include Rehabilitation Services. Up to 100 visits per Benefit Period. (Combined In and Out-of-Network)
Hospice Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Up to 210 days per lifetime (Combined In and Out-of-Network)
Skilled Nursing Facility Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Services require Prior Authorization. Up to 100 days per Benefit Period. (Combined In and Out-of-Network)
Durable Medical Equipment; Prosthetics & Orthotics	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Some equipment/supplies require Prior Authorization.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay after Deductible	30% Coinsurance after Deductible	May be provided at home. Some services require Prior Authorization. Up to 60 combined visits per Benefit Period (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay after Deductible	30% Coinsurance after Deductible	Limited to treatment of Autism Spectrum Disorder. Habilitation Services for conditions other than Autism Spectrum Disorder follow the Rehabilitation Services benefit, including its Cost-Sharing and visit limits. Services require Prior Authorization.
Applied Behavioral Analysis	$25 Copay after Deductible	30% Coinsurance after Deductible	Limited to treatment of Autism Spectrum Disorders. Services require Prior Authorization.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy. See Preventive Services for tubal ligation. Limited to vasectomy
Voluntary Term of Pregnancy	See Outpatient Surgical Services	See Outpatient Surgical Services	During first trimester only. Limited to 1 within a 24 month period.
Infertility Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Services require Prior Authorization.
Assisted Reproductive Technologies	10% Coinsurance after Deductible	30% Coinsurance after Deductible	One attempt per lifetime (Combined In and Out-of-Network)
Temporomandibular Joint Disorder Treatment	Not Covered	Not Covered	
Outpatient Prescription Drugs (Affiliated Pharmacy Providers only)			
Tier 1	$10 Copay 30 - day supply, $20 Copay 90 - day supply after Deductible		Tier 5 and 6 drugs are restricted to up to a 30-day supply per fill. In rare cases, an exception applies and a larger supply may be approved. If a Copay or Maximum applies, you will pay double the amount for a 31-60-day supply and triple the amount for a 61-90-day supply.
Tier 2	$10 Copay 30 - day supply, $20 Copay 90 - day supply after Deductible		
Tier 3	$50 Copay 30 - day supply, $100 Copay 90 - day supply after Deductible		
Tier 4	$50 Copay 30 - day supply, $100 Copay 90 - day supply after Deductible		
Tier 5	$50 Copay 30 - day supply at specialty pharmacy only after Deductible		
Tier 6	$50 Copay 30 - day supply at specialty pharmacy only after Deductible		
Infertility Drugs	50% Coinsurance after Deductible		

QHDHP

- Self-funded PPO plans are administered by Alliance Health and Life Insurance Company (Alliance), a wholly owned subsidiary of Health Alliance Plan.
- This document provides a general overview of your benefits. It is not a contract or legal document. If there is a conflict between this document and the terms and conditions of your Benefit Guide, the terms and conditions of your Benefit Guide, the Schedule of Benefits and any attached Riders will apply.
- This plan includes a network of health care providers through which services are covered at the In-Network Level of Benefits. If you receive Covered Services provided by Non-Affiliated Providers, they will be processed at the lower Out-of-Network Level of Benefits.
- You must notify Alliance prior to an elective hospital admission. Alliance must be notified within 48 hours after any emergency hospital admission. If Alliance is not notified, your benefits may be reduced or denied.
- Some services require Prior Authorization. Failure to obtain Prior Authorization before receiving services could result in a reduction or denial of benefits.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

Preventive Services Guide for Members Other Than Medicare Members

What are preventive services: Preventive services are tests or procedures provided to keep you healthy by looking for health issues or risks in people who don't have any diagnosis, history, or other known risk factors. It's meant to help prevent illness or find problems before any symptoms arise. The Benefit Administration Manual policy for Preventive Services gives more information such as ages, frequency as well as specific codes. Your doctor has access to tools that list the specific codes identified by HAP as preventive services.

What aren't preventive services: Services obtained to evaluate a complaint or symptom; in greater frequency or at different ages than recommended for screening; obtained out of network; or billed with service codes not designated as preventive. Tests used for these purposes are called diagnostic tests.

Product type and Recommendations: Coverage of preventive services for employer and individual products are based on United States Preventive Task Force Recommendations and Affordable Care Act recommendations. Medicare/Senior Plus based products are based on Medicare preventive services and are not addressed by this document. Medicaid/HAP Empowered products are based on USPSTF and ACA recommendations. Some products may not have coverage for "preventive services", please see Member's subscriber documents.

What's a well visit: A well visit is an evaluation scheduled at recommended intervals to check on your health status and point out concerns or risks that might prompt further investigation to maintain optimal health. A well visit is also known as a check-up. Visits to address a complaint such as a stomachache or an earache aren't considered well visits.

NOTE: The below charts reflect very basic information, not every test or service is listed. This document is intended as a guide and doesn't guarantee services. Please see the Benefit Administration Manual policy for the most current coverage information.

Infants, Children and Teens	**Member eligibility**	**Frequency** as a preventive service. Additional tests are covered as other medically necessary services.
Well child visits including but not limited to height, weight, growth & development.	All ages	Frequency follows American Academy of Pediatric recommendations based on child's age.
Healthy living:		
Autism screening	All ages	Annual. Intended as a component of a Well Child visit.
Behavioral screening	All ages	Annual. Intended as a component of a Well Child visit.
Depression & Anxiety screening	All ages	Annual. Intended as a component of a Well Child visit.
Developmental screening	All ages	Annual. Intended as a component of a Well Child visit.
Hearing & Vision screening	All ages	Annual. Intended as a component of a Well Child visit.

Obesity counseling & screening	All ages	Annual. Intended as a component of a Well Child visit.
Prevention of dental caries	All ages	Annual. Intended as a component of a Well Child visit.
Pregnancy counseling	Teens	Annual. Intended as a component of a Well Child visit.
Cervical cancer counseling,	Teens	Annual. Intended as a component of a Well Child visit.
HIV counseling & screening	Teens	Annual. Intended as a component of a Well Child visit.
Sexually transmitted infections counseling & screening	Teens	Twice per year
• Alcohol counseling & screening • Tobacco counseling & screening • Substance use counseling & screening	Teens	Annual. Intended as a component of a Well Child visit.
Immunizations: • Includes the Seasonal Flu shot, and all vaccines recommended for children.	Age-appropriate	Frequency as recommended by the American Academy of Pediatrics.
Preventive medications: • Iron supplements for infants at risk for anemia • Topical gonorrhea prophylactic medication • Fluoride varnish • HIV preexposure prophylaxis	• Infants • Newborns • Children under 5yrs old • Teens	• As indicated for the individual child • Once (billed as part of hospital stay) • Frequency as recommended by the American Academy of Pediatrics • Must meet criteria, covered as indicated.
Tests:		
• Newborn screening, • Sickle cell screening, • Bilirubin screening, • PKU screening • Thyroid screening	Infants	Once, each
• Anemia screening	All ages	Annual
• Cholesterol screening	All ages	Annual
• Lead screening	All ages	Annual
• TB skin testing	Age-appropriate	Annual
• Hepatitis B & C screening	Teens	Annual
• Refractive vision and hearing evaluations	Age-appropriate	Annual

Pregnancy *(In addition to all age-appropriate non-prenatal care)*	**Member eligibility**	**Frequency** as a preventive service.
Well Prenatal visits [also known as **routine prenatal visits**] including but not limited to weight and blood pressure monitoring, fetal heartbeat and fundal height monitoring.	All ages.	Frequency based on the American College of Obstetrician/Gynecologist recommendations.
Healthy living:		
• Alcohol counseling & screening • Substance use counseling & screening	All pregnant Members	Intended as a component of a Well prenatal visit.
• Tobacco counseling & screening • Tobacco cessation behavioral interventions	All pregnant Members	Intended as a component of a Well prenatal visit.
Anxiety screening	All pregnant Members	Intended as a component of a Well prenatal visit.
Depression screening	All pregnant Members	Frequency based on the American College of Obstetrician/Gynecologist recommendations. Intended as a component of a Well prenatal visit.
Healthy weight assessment & counseling	All pregnant Members	Intended as a component of a Well prenatal visit.
Hypertension & Pre-Eclampsia counseling & screening	All pregnant Members	Intended as a component of a Well prenatal visit.
Intimate partner violence,	All pregnant Members	Intended as a component of a Well prenatal visit.
Immunizations:	All pregnant Members	All recommended immunizations
Preventive medications: • Aspirin, Preeclampsia prevention • HIV preexposure prophylaxis	For Members at high risk	• After the first 12 weeks of pregnancy. • Must meet criteria, covered as indicated.
Breastfeeding supports: • Lactation instruction and support • Breast pump equipment & supplies	All pregnant or lactating Members	• Pre and postnatal • One breast pump per pregnancy
Tests		
Diabetes screening	All pregnant Members	Twice during pregnancy
Hepatitis B & C, HIV, & Sexually transmitted infections screening	All pregnant Members	Once during pregnancy
Asymptomatic Bacteriuria screening	All pregnant Members	Once per pregnancy
Rh assessment	All pregnant Members	Once each pregnancy (twice if Rh negative)
Fetal ultrasound	All pregnant Members	One per fetus

Adult Members	Member eligibility	**Frequency** as a preventive service. Additional tests are covered as other medically necessary services.
Well visits including but not limited to height, weight, heart rate, blood pressure	All ages	Annual
Healthy living:		
Advance care planning	All ages	Annual. Intended as a component of a Well visit.
Alcohol, Tobacco, and substance use counseling & screening	All ages	Annual. Intended as a component of a Well visit.
Anxiety screening	All ages	Intended as a component of a Well visit.
Cancer risk assessment • BRCA assessment & counseling • Cervical cancer screening • Colorectal cancer screening • Lung cancer counseling & screening • Prostate cancer screening • Skin cancer prevention counseling	All ages	Annual. Intended as a component of a Well visit.
Breast Cancer Genetic counseling	All ages	Once. Members at increased risk
Contraception including sterilization by tubal ligation.	All ages	Counseling and education intended as a component of a well visit.
Depression screening	All ages	Annual. Intended as a component of a Well visit.
Fall risk assessment/prevention	All ages	Annual. Intended as a component of a Well visit.
Hearing & Vision screening	All ages	Annual. Intended as a component of a Well visit.
HIV preexposure prophylaxis	For Members at high risk	As recommended by the CDC.
High blood pressure, hypertension counseling & screening	All ages	Annual. Intended as a component of a Well visit.
Intimate partner violence screening	All ages	Annual. Intended as a component of a Well visit.
Obesity, healthy diet and healthy lifestyle counseling & screening	All ages	Frequency based on service. Intended as a component of a Well visit.

Prediabetes & Type 2 Diabetes counseling & screening	All ages	Annual. Intended as a component of a Well visit.
Sexually transmitted infections counseling	All ages	Twice per year.
Tobacco smoking cessation – counseling & behavioral interventions	All ages	Eight visits/year. Intended as a component of a Well visit.
Urinary Incontinence counseling & screening:	All ages	Annual. Intended as a component of a Well visit.
Healthy weight assessment and counseling	All ages	Annual. Intended as a component of a Well visit.
Immunizations & Booster shots (*including but not limited to the following*) • Flu shot (seasonal) • Hepatitis A, B, HIV, meningococcal • Pneumococcal • Shingles • Tetanus • All other routine recommended vaccines	• All Members • If high risk • If high risk or over age 65 • If high risk or over age 60 • All ages • Age-appropriate	• Seasonal • As recommended by the CDC • As recommended by the CDC • As recommended by the CDC • Every 10 years • As recommended by the CDC
Preventive medications: • BRCA medication for prevention • Folic acid • HIV preexposure prophylaxis • Statins	• All ages • All ages • All ages • 40-75 yrs	• Member must meet criteria • Member of childbearing age • Member must meet criteria • As directed.
Contraceptives: • All Food & Drug Administration approved contraceptive methods including emergency contraceptives, tubal ligation procedures, and related counseling and education.	Female Members	As prescribed by provider for preventive purposes, consistent with ACA & HRSA guidelines and subject to subscriber contracts.
Tests:		
Cholesterol testing	All Adult Members	Annual
Diabetes screening, (Hemoglobin A1C)	All Adult Members	Annual
Hepatitis B & C, HIV, & STD screening	All Adult Members	Frequency based on testing
Lead screening	All Adult Members	Annual
TB skin testing	All Adult Members	Annual
BRCA genetic testing	All Adult Members	Once. Must meet criteria.
Screening procedures & tests:		
Abdominal aortic aneurysm screening	Male Members age 65- 75 with history of	Once per lifetime

	smoking	
Breast cancer screening (mammograms)	Female Members over age 40 years and those at increased risk	Screening mammogram: every one to two years
Cervical cancer screening (pap smears)	All Adult Members	Frequency based on type of testing
Colorectal cancer screening	All Adult Members	Frequency based on type of testing
Diabetic retinopathy screening	All Adult Members with Diabetes	Annual
Glaucoma screening	All Adult Members	Annual
Lung Cancer screening	Age 50-80 meeting criteria	Annual
Osteoporosis screening (Bone density testing)	Adult members meeting criteria	Every two years
Prostate cancer screening	All Adult Members	Annual
Refractive Vision and hearing evaluation	All Adult Members	Annual
Sexually transmitted infections screening (including Chlamydia & Gonorrhea, syphilis)	All Adult Members	Annual

Please note: Coverage as a preventive service with no Member cost share is based on the use of billing codes listed as specific preventive services and network limitations as described in the Related Benefit Administration Manual policies:

- **Preventive Services for Members Other Than Medicare Members**
- **Preventive Service: Mammography**
- **Preventive Services - Colorectal Cancer Screening for Members OTHER THAN Medicare Advantage Members**
- **Drug Therapy for Smoking Cessation - OTC Smoking Cessation Products**
- **Routine Prenatal Care**

Medicare plan Members are not addressed by this document. Please refer to the Benefit Administration Manual policies:

- **Preventive Services for Medicare Advantage Members**
- **Preventive Service: Mammography**
- **Preventive Services - Colorectal Cancer Screening for Medicare Advantage Members**

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