Updates to your 2025 Medicare Advantage plan

Dear Valued Member,

Thank you for being a HAP member. We want to keep you informed about a few changes to your Medicare Advantage plan for 2025. The information enclosed is an important update to your plan next year.

Please note: You do not need to take any action. You will be automatically renewed into your HAP Medicare Advantage plan.

What's changing?

- **Expanded Dental Coverage**: our dental plan now covers some of the most common procedures, such as crowns and bridges.
- **New Flex Cards:** a pre-paid MasterCard you can use for over-the-counter purchases and healthy food for those who qualify.
- **New and improved HAP App:** find a doctor and view your benefits and claims easily from your smartphone.
- **Pharmacy Payment Options:** More convenient options to make your medication more affordable.

As part of the Inflation Reduction Act, health plans needed to make some changes. Moving forward, you will never pay more than $2,000 out of pocket for prescription expenses. Some other benefits and cost shares may have to be adjusted as a result.

What's next?
We know Medicare can be confusing, especially when things change. It's our goal to make it easy.

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

While reading it, you might have a question or two. If so, we offer personalized ANOC reviews. A Medicare navigator will walk you through the upcoming changes specific to your plan.

For your personal ANOC review, please call us at:

1-833-HAP-HERE (1-833-427-4373)

Hours of Operation:

8:30 a.m. to 7:00 p.m.

From Oct. 1 – Dec. 20

To contact HAP customer service, please call:

HMO: (800) 801-1770 (TTY: 711)

PPO: (888) 658-2536 (TTY: 711)

Hours of operation:

Oct. 1 – Mar. 31
8 a.m. – 8 p.m.
Seven days a week

Apr. 1 – Sept. 30
8 a.m. – 8 p.m.
Monday – Friday

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

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

Sincerely,

HAP Customer Service

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

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

Annual Notice of Changes for 2025

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

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

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

What to do now

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

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

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

OMB Approval 0938-1051 (Expires: August 31, 2026)

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☐ Think about whether you are happy with our plan.

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

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

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

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

- If you don't join another plan by December 7, 2024, you will stay in *HAP Senior Plus*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with *HAP Senior Plus*.
- If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

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

About *HAP Senior Plus*

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

- When this document says "we," "us," or "our," it means *Alliance Health and Life Insurance Company (HAP Senior Plus (PPO))*. When it says "plan" or "our plan," it means *HAP Senior Plus*.

Y0076_2025 ANOC PPO 008_M

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *HAP Senior Plus (PPO)* in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$165	$165
Deductible	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: $4,000 From network and out-of-network providers combined: $4,000	From network providers: $4,000 From network and out-of-network providers combined: $4,000
Doctor office visits	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $25 Copay per visit **Out-of-Network** Primary care visits: 25% Coinsurance per visit Specialist visits: 25% Coinsurance per visit	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $25 Copay per visit **Out-of-Network** Primary care visits: 25% Coinsurance per visit Specialist visits: 25% Coinsurance per visit

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	**In-Network** $250 Copay per day for days 1 - 5 $0 Copay per day for days 6 - 90 **Out-of-Network** You pay 25% Coinsurance per admission	**In-Network** $250 Copay per day for days 1 - 5 $0 Copay per day for days 6 - 90 **Out-of-Network** You pay 25% Coinsurance per admission
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost sharing:* $9 *Preferred cost sharing:* $0 • Drug Tier 2: *Standard cost sharing:* $17 *Preferred cost sharing:* $11 • Drug Tier 3: *Standard cost sharing:* $47 You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* $41 You pay $25 per month supply of each covered insulin product on this tier. • Drug Tier 4: *Standard cost sharing:* 50% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 48%	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost sharing:* $9 *Preferred cost sharing:* $0 • Drug Tier 2: *Standard cost sharing:* $17 *Preferred cost sharing:* $11 • Drug Tier 3: *Standard cost sharing:* 22% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 20% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: *Standard cost sharing:* 50% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 48%

Cost	2024 (this year)	2025 (next year)
	You pay $25 per month supply of each covered insulin product on this tier. • Drug Tier 5: *Standard cost sharing:* 33% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 33% You pay $25 per month supply of each covered insulin product on this tier. • Drug Tier 6: *Standard cost sharing:* $0 *Preferred cost sharing:* $0 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.	You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: *Standard cost sharing:* 33% You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 33% You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *HAP Senior Plus (PPO)* in 2025

If you do nothing by December 7, 2024, we will automatically enroll you in our *HAP Senior Plus*. This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through *HAP Senior Plus*. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$165	$165
Optional dental plan monthly premium	Delta Dental 50 Member Pays $19.10 per month Delta Dental 70 Member Pays $29.50 per month Delta Dental 100 Member Pays $51.90 per month	Delta Dental 50 Member Pays $19.90 per month

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

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

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

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. If you choose an optional supplemental dental plan, your plan premium and your costs for services also do not count toward your maximum out-of-pocket amount.	$4,000	$4,000 Once you have paid $4,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services. If you choose an optional supplemental dental plan, your plan premium and your costs for services	$4,000	$4,000 Once you have paid $4,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Cost	2024 (this year)	2025 (next year)
also do not count toward your maximum out-of-pocket amount.		

Section 2.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

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

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory*** hap.providerlookuponlinesearch.com/search **to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory*** hap.providerlookuponlinesearch.com/search **to see which pharmacies are in our network.**

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

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2024 (this year)	2025 (next year)
Ambulance Services	**In-Network:** You pay a $250 copay for ambulance services per trip.	**In-Network:** You pay a $250 copay for ambulance services per trip.

Cost	2024 (this year)	2025 (next year)
Ambulance Services (Continued)	**Out-Of-Network:** You pay 25% Coinsurance of the total cost for ambulance services per trip.	**Out-Of-Network:** You pay $250 copay for this for ambulance services per trip.
Companion Care	Companion care is covered.	Companion care is not covered.
Dental Services	There is **$3,000** allowance for all dental services per year. You pay nothing for 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, 1 set of bitewing x-rays and bridge repairs. You pay 50% coinsurance for root canals, fillings, crown repairs, simple extractions and oral surgery. Must use a Premier or PPO Delta Dental provider.	There is **$2,000** allowance for all dental services per year. You pay nothing for 2 oral exams, 2 cleanings or 2 periodontal cleanings, 2 fluoride treatments, brush biopsy, 1 set of bitewing x-rays. You pay 50% coinsurance for root canals, fillings, **onlays, crowns**, crown repairs, simple extractions and oral surgery. Bridge repairs are not covered. Must use a **PPO Delta Dental provider**.
Flex Card The food and produce benefit is a special supplemental benefit for the chronically ill (SSBCI) and is made available to members with one or more qualifying chronic conditions. Not all members will qualify for this benefit. Qualifying chronic conditions include but are not limited to diabetes, cardiovascular disorders, chronic lung disorders, cancer, and dementia. For a	Flex card is not covered.	$125 allowance per quarter with rollover to next quarter for Over the counter (OTC) drugs and healthy food/produce (for eligible members) from NationsOTC online catalog or from a retail store. You will receive a prepaid Benefits Mastercard to use for this benefit.

Cost	2024 (this year)	2025 (next year)
Flex Card (Continued) complete list of qualifying chronic conditions please see the plan's Evidence of Coverage (EOC).		
Hearing Aids	You pay a $689 copay for basic technology hearing aids. You pay a $989 copay for prime technology hearing aids. You pay a $1,539 copay for advanced technology hearing aids. You pay a $2,039 copay for premium technology hearing aids. Must use NationsHearing.	You pay a $0 copay for value technology hearing aids. You pay a $175 copay for basic technology hearing aids. You pay a $475 copay for prime technology hearing aids. You pay a $775 copay for preferred technology hearing aids. You pay a $1,075 copay for advanced technology hearing aids. You pay a $1,575 copay for premium technology hearing aids. Must use NationsHearing.
Memory Fitness (BrainHQ®)	Memory fitness provided by BrainHQ is not covered.	You pay nothing for memory fitness provided by BrainHQ. BrainHQ is an online, evidence-based brain health program to address your overall brain health. You can register for BrainHQ at

Cost	2024 (this year)	2025 (next year)
Memory Fitness (BrainHQ®) (Continued)		hap.brainhq.com or by calling 800-514-3961.
Outpatient Diagnostic Tests	**In-Network:** You pay nothing for peripheral vascular disease ultrasounds, pacemaker testing or allergy testing per visit. **Out-Of-Network:** You pay nothing for peripheral vascular disease ultrasounds, pacemaker testing or allergy testing per visit.	**In-Network:** You pay nothing for peripheral vascular disease ultrasounds, pacemaker testing or allergy testing per visit. **Out-Of-Network:** You pay 25% Coinsurance of the total cost for peripheral vascular disease ultrasounds, pacemaker testing or allergy testing per visit.
Over-the-Counter (OTC) Items The food and produce benefit is a special supplemental benefit for the chronically ill (SSBCI) and is made available to members with one or more qualifying chronic conditions. Not all members will qualify for this benefit. Qualifying chronic conditions include but are not limited to diabetes, cardiovascular disorders, chronic lung disorders, cancer, and dementia. For a complete list of qualifying chronic conditions please see the plan's Evidence of Coverage (EOC).	You pay nothing for this benefit. There is $100 allowance every three months for approved OTC items. The quarterly benefits will roll over to the next quarter and must be used by the end of the year. Must use NationsOTC online catalog. Food and produce are covered for qualified individuals.	You have a Flex Card benefit that now includes coverage for eligible OTC items. There is a combined allowance of $125 every three months that may also be used towards OTC items. The quarterly allowance will roll over to the next quarter and must be used by the end of the year. May use NationsOTC online catalog or a participating retail store. Food and produce are covered for qualified individuals. You will

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) Items (Continued)		receive a Prepaid Benefits Mastercard to use for this benefit.
Personal Emergency Response System (PERS)	PERS is a covered benefit.	PERS is not covered.
Skilled Nursing Facility (SNF)	**In-Network:** You pay a $203 Copay for days 21-100 for SNF care. **Out-of-Network:** You pay 25% Coinsurance for each covered day for SNF care.	**In-Network:** You pay a $214 Copay for days 21-100 for SNF care. **Out-of-Network:** You pay 25% Coinsurance for each covered day for SNF care.
World-wide Emergency Services	You pay a $90 copay for emergency care per visit.	You pay a $125 copay for emergency care per visit.
World-wide Urgently Needed Services (Includes telehealth visits)	You pay a $55 copay for world-wide urgently needed services per visit.	You pay a $45 copay for world-wide urgently needed services per visit.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If

we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, please call Customer Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage

Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on *Tier 3* your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** For 2024 you paid a $41 (Preferred) /$47 (Standard) copayment for drugs on Tier 3 (Preferred Brand). For 2025 you will pay *20%(Preferred)/22%(Standard)* coinsurance for drugs on this tier. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you	Your cost for a one-month supply is: **Preferred Generics:** *Standard cost sharing:* You pay $9 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Generics:** *Standard cost sharing:* You pay $17 per prescription. *Preferred cost sharing:* You pay $11 per prescription. **Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription.	Your cost for a one-month supply is: **Preferred Generics:** *Standard cost sharing:* You pay $9 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Generics:** *Standard cost sharing:* You pay $17 per prescription. *Preferred cost sharing:* You pay $11 per prescription. **Preferred Brand:** *Standard cost sharing:* You pay 22% of the total cost.

Stage	2024 (this year)	2025 (next year)
	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $47. *Preferred cost sharing:* You pay $41 per prescription. You pay $25 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $41. **Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost. You pay $25 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 48% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost.	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 22%. *Preferred cost sharing:* You pay 20% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 20%. **Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 48% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost.

Stage	2024 (this year)	2025 (next year)
	You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 33% of the total cost. You pay $25 per month supply of each covered insulin product on this tier. **Select Care Drugs:** *Standard cost sharing:* You pay $0 per prescription. *Preferred cost sharing:* You pay $0 per prescription. __________ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. __________ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stages

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

HAP has administrative changes for 2025. The changes are summarized below.

Cost	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not Applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January - December). To learn more about this payment option, please contact us at 1-866-845-1803 or visit Medicare.gov.
Service Area	Service area consists of: Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, Monroe, Montcalm, Newaygo, Oakland, Oceana, Osceola, Ottawa, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Van Buren,	Service area consists of: Allegan, Arenac, Barry, Bay, Berrien, Branch, Calhoun, Clare, Clinton, Eaton, Genesee, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kent, **Lake**, Lapeer, Lenawee, Livingston, Macomb, Mason, Mecosta, Midland, **Missaukee**, Monroe, Montcalm, Newaygo, Oakland, Oceana, **Ogemaw**, Osceola, Ottawa, **Roscommon**, Saginaw, Sanilac,

Cost	2024 (this year)	2025 (next year)
Service Area (Continued)	Washtenaw, Wayne counties.	Shiawassee, St.Clair, Tuscola, Van Buren, Washtenaw, Wayne counties.

SECTION 4 Deciding Which Plan to Choose

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

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

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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

Step 2: Change your coverage

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

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

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

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

If you enrolled in a Medicare Advantage Plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

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

SECTION 6 Programs That Offer Free Counseling about Medicare

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

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

SECTION 7 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free).For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

"Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at (866) 845-1803 or visit Medicare.gov

SECTION 8 Questions?

Section 8.1 – Getting Help from *HAP Senior Plus*

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

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for *HAP Senior Plus.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://www.hap.org/medicare/member-resources/medicare-plan-information/additional-information/forms. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

HAP Senior Plus Customer Service

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

Michigan Medicare Assistance Program

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

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

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