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All Products

Introduction
This Health Alliance Plan (HAP) Group Operating Manual is designed to provide employers and benefit administrators with information and guidance concerning HAP group coverage and operational policies and procedures.

Product Lines:
- HMO .................. (also referred to as HAP)
- PPO/EPO ............. (also referred to as Alliance Health and Life Insurance Company)
- Group Medicare... (also referred to as HAP Senior Plus and Alliance Medicare PPO)

Please consider this manual as a reference tool whenever questions arise concerning the administration or application of the product(s).

This manual is neither intended nor expected to replace direct communication with your sales representative. Rather, we hope it will enhance communication with your sales representative and other HAP personnel. If you have any questions, or need additional assistance, please contact your sales representative.

This manual contains important instructions on how to administer your group coverage. Specific attention should be given to the operational requirements and obligations that are outlined in this manual.

This manual is not intended to revise and/or conflict with your HAP Contract and Certificates. If such a conflict were to arise, the terms of those Contracts will control.
**Important Contact Information**

**Member Resources**

Our clients come first! Our Client Services department is committed to outstanding service. When any HAP member has a question about services or benefits, Client Service Specialist contact information may be located on the *Contact Us* page at [hap.org](http://hap.org) or select from the following options:

| Alliance Health and Life Insurance Company (PPO/EPO) | Detroit Area: *(313) 664-7010*  
Toll-Free: *(888) 999-4347*  
Automated Services Toll-Free: *(877) 427-3678*  
7 a.m. to 7 p.m. (Eastern Time), Monday through Friday and Saturdays from 8 a.m. to noon  
Submit written inquiries to:  
Client Services  
ATTN: Alliance  
2850 West Grand Boulevard  
Detroit, MI 48202 |
|---|---|
| Health Alliance Plan (HMO) | Detroit Area: *(313) 872-8100*  
Toll-Free: *(800) 422-4641*  
Telecommunications Device for the Deaf (TDD): *(313) 664-8000*  
7 a.m. to 7 p.m. (Eastern Standard Time), Monday through Friday on Saturdays 8 a.m. to noon  
Submit written inquiries to:  
Client Services  
ATTN: HMO  
2850 West Grand Boulevard  
Detroit, MI 48202 |
| Group Retiree Plans  
HAP Senior Plus and Alliance Medicare PPO Plans | Detroit Area: *(313) 664-9050*  
Toll-free: *(888) 658-2536*  
8 a.m. to 8 p.m. (Eastern Time), Monday through Friday on Saturdays 8 a.m. to noon  
Submit written inquiries to:  
HAP Client Services  
ATTN: Medicare  
2850 West Grand Boulevard  
Detroit, MI 48202 |

Each HAP member, once registered on [hap.org](http://hap.org), has access to a Member Kit (located under the My Plan tab/Member Resources) which contains information regarding ID Cards, what to do in an emergency, urgent care, students away at school, prescriptions, claims, continuity of care, etc.
**Group Resources**
Thirty (30) days after you have purchased coverage, our dedicated service representative will send you a letter with their name and contact information listed. This service representative will assist you with general health plan questions and work with you during your group’s annual renewal process.

Our enrollment specialist and billing specialist are listed on your Monthly Billing Invoice. Contact them for any questions regarding enrollment activity or billing statements. Your Group Number(s) are an important identifier and are listed on your Monthly Billing Invoice.

Below is a list of services and the respective contact numbers. Please direct calls/inquires pertaining to the following categories to the appropriate unit as listed:

<table>
<thead>
<tr>
<th>Claims</th>
<th><strong>HAP’s Direct Service Line</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits/Coverage</td>
<td>(313) 664-9110</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>(800) 950-7455</td>
</tr>
<tr>
<td>Cost sharing</td>
<td>Monday–Friday, 8 a.m. - 5 p.m.</td>
</tr>
<tr>
<td>Coordination of Benefits/Medicare</td>
<td><a href="mailto:Hap_direct@hap.org">Hap_direct@hap.org</a></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Annual renewals</th>
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<tr>
<td>Rate inquires</td>
<td>Directly to Account</td>
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<tr>
<td>Provider directories</td>
<td>Manager/Representative</td>
</tr>
<tr>
<td>Open enrollment</td>
<td>Monday–Friday, 8 a.m. - 5 p.m.</td>
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<tr>
<td>Materials and meetings</td>
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<table>
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<tr>
<th>Member</th>
<th><strong>Membership &amp; Billing Enrollment</strong></th>
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</tr>
<tr>
<td>• Verification</td>
<td>Specialist as listed on invoice</td>
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<tr>
<td></td>
<td>Monday–Friday, 8 a.m. - 4 p.m.</td>
</tr>
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<table>
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<th>Member</th>
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</tr>
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<tbody>
<tr>
<td>• Billing Issues</td>
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</tr>
<tr>
<td>• Payment questions</td>
<td>Specialist as listed on invoice</td>
</tr>
<tr>
<td></td>
<td>Monday–Friday, 8 a.m. - 4 p.m.</td>
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</tbody>
</table>
Monthly Billing Invoice
HAP currently maintains a billing system that reflects payment according to monthly invoiced charges. This billing system contains pertinent employee/covered dependent information that will significantly enhance your ability to reconcile membership change(s) that you have requested. It identifies all additions, deletions, and changes in service for each month billed (noted on invoice), as well as any retroactive changes.

The Monthly Billing Invoice of your group is produced by the 15th of each month for membership changes in the upcoming month. For example, for the coverage period of August 1st through August 31st, bill generation will occur on or before July 15th.

In addition, please note that any activity not reported by the invoice generation date, will be reflected on the invoice with the appropriate retroactive charges. However, for any request for changes in excess of thirty (30) days, HAP reserves the right to review the request and grant or deny the exception.

Premium Payment Options for Group Accounts

1. Electronic Funds Transfer (EFT) – Payment is sent electronically each month. The EFT payment must be sent by the due date.
   • Contact your HAP Sales Representative to request an EFT form.
   • Once the completed EFT form is approved, the requestor will be notified.

2. Automatic Withdrawal – Payment is withdrawn on the last business day of the month prior to the invoice due date.
   • To request an automatic withdrawal form, please contact Lisa Vazquez in the Receivables department at (248) 443-8520.

3. Regular Mail – Premium payments sent via US mail.
   • Coupon must be included with premium payment.
   • If the coupon is not available, include the group number(s) on the check.
   • Mail payments to:
     Health Alliance Plan (HAP)  Health Alliance Plan (Alliance)
     Dept. 271101  Dept. 270301
     P.O. Box 55000  P.O. Box 67000
     Detroit, MI 48255-2711  Detroit, MI 48267-2703
4. Overnight Mail – Premium payments sent overnight by FedEx, UPS, etc.
   • Coupon must be included with premium payment.
   • If the coupon is not available, include the group number(s) on the check.
   • Mail payments to:
     Health Alliance Plan (HAP)
     2850 W. Grand Blvd.
     Detroit, MI 48202
     Attn: Receivables department.

5. Lobby Payment – Premium payments can be dropped off at the Detroit or Southfield customer service centers.
   • Detroit Address:
     Health Alliance Plan
     2850 W. Grand Blvd.
     Detroit, MI 48202
   • Southfield Address:
     Health Alliance Plan
     21700 Northwestern Hwy.
     Southfield, MI 48075

You are responsible for reconciling the invoice with HAP and verifying your covered employees on a monthly basis. Your monthly invoice contains the following, if applicable:
   • Additional comments
   • Current charges and Activity Report
   • Supporting Activity Detail (current and/or retroactive)
   • Group Billing Enrollment Register and Summary Report

Remit Billing Invoice Coupon and payment to:
Health Alliance Plan
Department 271101
P.O. Box 55000
Detroit, MI 48255-2711

Payment is due by the due date listed on the invoice. If payment is not received by the due date, your group is subject to cancellation.
**Premium Charges Related to Additions/Deletions**  
Any changes which require the addition or deletion of employees/covered dependents such as changing of a name or canceling member coverage, should be reported to HAP’s Membership and Billing department.

The following criteria are used in the calculation of a group’s premium:
- HAP uses the first through the 15th rule for calculating policy additions, deletions, and service changes, with the exception of marriages and births.

Under this rule if an employee/covered dependent is:
- Effective between the first through the 15th of the month, the premium will be charged for that month.
- Effective after the 15th of the month, coverage will be effective, but the premium is charged the first of the following month.
- Canceled the first through the 15th of the month, no premium will be charged for that month.
- Canceled after the 15th of the month, the full premium is due for that month.

The new premium and rate for marriages and births will not be charged until the first of the following month, unless the event occurs on the first of the month.

**Centers for Medicare and Medicaid Services (CMS)**  
It is your responsibility to provide information and respond to HAP regarding any Primary Payment Notice (PPN) or Medicare Secondary Payor (MSP) notices you receive.

**Primary Payment Notice (PPN)**  
The PPN correspondence will include:
- A cover letter
- A PPN Worksheet including employees/covered dependents that are Medicare beneficiaries

The PPN correspondence content will include:
- Coverage dates
- Medicare Health Insurance Claim (HIC) number
- Policy number and group ID
- Certification statement regarding the accuracy of the contents of the worksheet

You will be asked to complete, sign and forward the PPN to HAP promptly in order for the employee/covered dependent eligibility and employment status verification to be confirmed before forwarding to the MSP Recovery Contractor (MSPRC). Collaborating with HAP allows joint submission of accurate information, which will eliminate an MSP demand.

Each entity has forty-five (45) days to respond from the date of the PPN letter. If a response is untimely, the MSPRC will be unable to update Medicare records before an MSP demand is issued; and, the debtor will have to follow the valid documented defense process associated with the demand letter.
PPN Resources:
MSPRC - (866) 677-7220 8 a.m. to 8 p.m. Monday through Friday Eastern Daylight Time

Website Resources:
- msprc.info
- CMS.gov/COBGenerallInformation
- CMS.gov/MandatoryInsRep (This site has all official instructions for MMSEA Section 111 mandatory MSP reporting.)
- CMS.gov/manuals/IOM

If you have any questions regarding this information, please contact your Sales Representative.

Medicare Secondary Payer (MSP) Information
The MSP provisions of the Social Security Act state that Medicare may recover an incorrect payment from “any entity which is required or responsible” to pay for medical services under a primary plan. This includes an employer or group health plan sponsor, or an insurance company plan or program. The regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to the Federal Government are jointly and severally liable for payment of the debt. If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt.

You as the employer are required:
- To notify HAP within thirty (30) days of changes in employment status and Medicare enrollment status for any employee/covered dependent. Changes in employment status include retirement, termination, COBRA status, and no longer meeting current employment status as defined under MSP rules. You are required to provide the effective date for changes in employment status. You must report Medicare enrollment status for all employees/covered dependents when Medicare entitlement is based on age or disability, including reporting Medicare HIC number(s), and Medicare Part A and B effective and termination dates.
- To enforce eligibility requirements for all members as noted in your Contract/Policy. As such, you are required to submit enrollment termination notices to HAP on a timely basis and terminate coverage on the date when eligibility requirements are no longer met.
- To maintain and classify employees/covered dependents in separate group segments to appropriately reflect the employee employment status as it relates to MSP rules.

In the event you fail to enforce eligibility requirements or correctly classify your employees/covered dependents by employment status in a timely manner, HAP reserves the right to process enrollment changes upon giving you thirty (30) days notice, up to and including termination of employee/covered dependent coverage. Enrollment changes may be processed retroactively when MSP rules require correction to eligibility data to appropriately report and administer employee/covered dependent benefits.
In order to reduce your potential liability under MSP, you must immediately deliver a copy of all MSP notices and attachments to HAP. Please direct requests by mail to:

HAP
Coordination of Benefits (COB) Department
2850 West Grand Blvd.
Detroit, MI 48202
or send via fax to (248) 443-0090

You may also email a copy of the notice to your Sales Representative. In order to close the MSP demand case, you are responsible for providing, in a timely manner, additional information to HAP as deemed necessary by the COB department. Failure to notify HAP or provide additional timely information will prevent HAP from working the case and defending you against an MSP demand. This may result in an MSP debt and/or interest penalties being charged against you.

HAP’s Role
Upon receipt of your MSP notice, HAP will review the eligibility and payment records to confirm: group size, employment status, employee/covered dependent eligibility and payment responsibility based on COB rules and HAP’s previous payment history for the claims identified. After reviewing all available information, HAP will determine if a payment is required and will process the request accordingly. A written copy of HAP’s determination will be sent to both you and Medicare.

If HAP determines a refund is due Medicare, HAP will make payment directly to Medicare. **HAP will not be responsible for paying interest penalties on MSP demands that HAP did not receive in a timely manner.**

MSP Resources:

- Contact the Medicare Coordination of Benefits Contractor (COBC) with general Medicare Secondary Payer (MSP) questions or to report employment changes at (800) 999-1118.
- View a sample of a MSP demand at: http://msprc.info/includes/letters/docs/GHP%20Demand%20-%20Insurer%20copy.pdf
- Additional information:
  - http://www.cms.gov/EmployerServices/01_Overview.asp#TopOfPage

If you have any questions regarding this information, please contact your Sales Representative.
Reports
For Alliance Health and Life Insurance Company (Alliance) (PPO/EPO) groups with a minimum of 100 enrolled contracts...
For HAP (HMO) groups with a minimum of 1,000 enrolled members...

HAP has comprehensive reporting capabilities designed to summarize healthcare utilization and costs, compare statistics to normative data and assist in monitoring utilization trends and patterns. Working together to contain expenses, you and HAP can identify ways to optimize the use of health care benefits and identify unique health care needs. HAP is a partner in providing recommendations on innovative strategies for increased cost efficiencies.

Reports containing protected health information (PHI) need a release called an Employer Group Certification which follows HIPAA guidelines. This form identifies who in your company, your producer agency, etc. is designated to receive PHI, and will be kept on file at HAP.

Keeping your employee information current - specifically phone numbers, addresses, social security numbers - helps HAP provide you with the most up to date reporting, along with making it possible to contact your employees when necessary.

Supplies
Provider Directories
The most updated and current information can be found on the website at hap.org. Information on the website is updated nightly. Some of the on-line directories are quite large and may take a few moments to display. The paper Provider Directories are published several times a year and contain contracted providers. Contact your Sales Representative to order a supply of directories.

Employees/covered dependents should contact the Client Services Department as noted in the Important Contact Information at the beginning of this document, with any question regarding providers.

Forms
Most forms can be obtained online in the secure Employer portal at hap.org.

To sign up for online access to the secure Employer portal, contact your Sales Representative who will provide you with a user ID and Password.
HMO and Alliance Health and Life Insurance Company (Alliance)

Eligibility

Eligible Groups:
To qualify for group coverage you must have at least two (2) employees. If the two employees are comprised solely of husband and wife you will be considered a single member group with one dependent, and not a qualified group. The intent is to underwrite a group and not a family split up to form a group. If the group falls below the minimum of two (2) employees, it will be subject for review and determination of on-going coverage by Risk assessment, Revenue management and client Reporting (R3) who is responsible for underwriting.

If a group wants to add a new segment to the existing group, provide an up-to-date census of the new segment/group to the appropriate Service Representative. HAP’s Risk assessment, Revenue management and client Reporting (R3) department will review and make a determination.

Under HAP’s Underwriting Guidelines, the group must make a minimum contribution of 50% to the cost of benefit coverage.

Employees:
Eligible employees are defined in the HMO Contract/Alliance Policy. In addition:

• Each new or rehired eligible employee should be given the opportunity of selecting HAP at the time of employment according to your procedure and waiting period.
• Those employees who work a normal work week of 30 or more hours are considered full-time.

Those employees who work a normal work week of 17.5 to 30 hours are considered part-time.

• If an employer extends coverage to employees who are on an approved leave of absence or layoff, required by the employer’s personnel policies or union contract, all such employees are eligible.
• Employers should establish a policy for their employees to follow if they are “not actively at work”. These policies must be consistent with HIPAA requirements and HAP should be aware of how to follow (e.g., layoff, leave of absence, etc. on “X” date, effective by what return by date?).

Dependents:
The following persons are eligible for coverage as the employee’s covered dependent under the HAP/Alliance contract if they meet the eligibility requirements of HAP and the employer group:

1. The Employee’s spouse
2. Children to age 26:
   a. Reform (small) groups are covered until the end of year the dependent turns 26.
   b. Non-Reform (large) groups are covered based on the chosen criteria:
      i. Birthdate day
      ii. End of month
      iii. End of year
3. End of year Special Dependent Benefits (if purchased as additional benefit to the HMO Contract/Alliance
Policy). Provided such benefits are offered to employees in the group, coverage could be available to their dependents other than those previously described. These benefits are:

a. Sponsored Dependent Benefit: Any relative by blood or marriage, or other person (non-relative) who resides with the employee, and is reported as a dependent on the employee’s most recent federal income tax return. The sponsored dependent must not be eligible for Medicare nor otherwise eligible as a dependent under the terms set forth in the section entitled “eligibility” of the Contract/Policy.

b. Medicare Eligible Sponsored Dependent Benefit: This benefit will cover a person enrolled in Medicare Parts A and B who is either:
   A. The parent or grandparent of the employee or employee’s spouse, reported as a dependent on the employee’s most recent federal income tax return.
   B. Any other person (non-relative) who resides with the employee and for whom the employee reports as a dependent on the employee’s most recent federal income tax return.

c. Domestic Partner Benefit: Some groups choose to provide domestic partner coverage for opposite sex and/or same sex partners. The rules apply if applicable to your group. An individual who resides together with the employee and intends to do so permanently; who shares in basic living expenses; who is not related by blood to a degree of closeness what would prohibit marriage were the individual of the opposite sex; is at least the age of consent; who is not married or in a domestic partnership relationship with anyone else; who if eligible to register as domestic partners in the jurisdiction in which the employee lives or works would register as domestic partners within thirty-one (31) days of enrollment eligibility.

4. Permanently and totally disabled children over the age of 26 may be eligible for coverage as part of the family if they are:
   a. Incapable of self-sustaining employment by reason of mental retardation or a physical handicap.
   b. Disabled prior to the age of 26.
   c. Dependent on the employee for support and maintenance.

A statement from a doctor identifying the dependent’s diagnosis and the prognosis must be included with the application.
Employee/Dependent Changes

Please ensure that all required data elements are provided to HAP for proper enrollment of your employees and their covered dependents.

Changes may be submitted via:

- Membership and Record Change Form (see FORMS)
- **Electronic Data Interchange (EDI)**
  
  Contact Barbara Pitt, EDI Business Coordinator at Bpitt1@hap.org to establish EDI.

- **Internet access**
  
  Initially you will be provided a User ID and Password to access HAP’s secure Employer portal where you can manage employee/dependent/retiree group information online. Your Sales Representative can provide assistance if you forget your ID or password, or need information reset.

Log on at hap.org, look for and select the EMPLOYER tab.

Enter your ID and then your password.

From here, the *My Tools* tab allows you to:

- Add, cancel and modify members
- Reinstall members and request ID cards
- Generate enrollment reports of active members
- Use HAP’s e-billing application to review invoices and attachments
- Get updates and information on special HAP employer programs and activities
- Create a hard-copy report (excel spreadsheet, etc.) from you.

Requests to add dependents must adhere to qualifying events as described below. HAP generally allows thirty (30) day adjustments for a qualifying event. Anything in excess of one month is subject to review. Approvals will be considered as an exception to the policy if extraordinary circumstances contributed to the adjustment. To request an exception, contact your Enrollment Specialist and include an explanatory letter along with the enrollment/deletion information.

Effective dates of coverage for dependents added to the employee’s contract are:

<table>
<thead>
<tr>
<th>Event</th>
<th>Request Made</th>
<th>Coverage Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Within 30 days of marriage</td>
<td>Date of marriage</td>
</tr>
<tr>
<td>Newborn Child</td>
<td>Within 30 days of birth</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Legal Adoption</td>
<td>Within 30 days of petition for adoption or legal residence, whichever is later</td>
<td>Date of petition for adoption or legal residence, whichever is later</td>
</tr>
<tr>
<td>Legal Guardianship</td>
<td>Within 30 days of petition for guardian or legal residence, whichever is later</td>
<td>Date of petition for guardianship or legal residence, whichever is later</td>
</tr>
</tbody>
</table>
All employees/covered dependents must be removed when they are no longer eligible. Coverage of a dependent will cease as follows:

<table>
<thead>
<tr>
<th>Event</th>
<th>Coverage Ceases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce</td>
<td>Date of divorce</td>
</tr>
<tr>
<td>Attainment of maximum age 26</td>
<td>Until end of year, end of month, or date of birth,</td>
</tr>
<tr>
<td></td>
<td>based on the group criteria.</td>
</tr>
</tbody>
</table>

Generally member applications and other member eligibility documents are submitted directly to Membership and Billing (M&B). M&B maintains a group mailbox where staff and/or current groups and producers can forward HAP Member Applications and other member eligibility documents for processing. It is not intended for the submission of new business and should not be used for that purpose. All member eligibility documents can be scanned and then emailed to mb_enrollment@hap.org.

Faxes are accepted for urgent/emergent situations. Faxing should not be your standard process to send enrollment activity (add, deletes and service changes). Remember, you can manage your information any time at hap.org.

Paper changes should be mailed to:

Health Alliance Plan
ATTENTION: MEMBERSHIP AND BILLING DEPARTMENT
(Include name of Enrollment Specialist, as listed on your billing invoice)
2850 West Grand Boulevard
Detroit, MI 48202

**Qualified Medical Child Support Orders (QMSCO)**
Upon receipt of a QMSCO from the court (separate from a divorce decree), the entire court order must be submitted to HAP with the enrollment application. All routine care must be obtained within HAP’s delivery system.
Termination of Coverage*

Group Cancellation
If you wish to cancel your group coverage, you must provide written documentation to your Service Representative, thirty (30) days PRIOR to your cancellation date, with respect to any or all members.

*Not a complete list of Termination Guidelines. All enrollments must adhere to eligibility requirements as contained in the Group Operating Agreement, and Medicare Secondary Payer (MSP) guidelines (see Medicare Secondary Payer Information for Employers).

Member Cancellation
Disenrollment information for any reason must be submitted to HAP’s Membership and Billing Department within thirty (30) days of the event date.

Consolidated Omnibus Budgeted Reconciliation Act (COBRA)
If your organization employs at least twenty (20) full-time equivalent employees on at least half of the working days during the previous year, you’re required by law to offer coverage through COBRA when an employee loses coverage through your regular plan.

It is your responsibility to notify all employees/covered dependents regarding their COBRA rights and to provide written notice at the time they become eligible for COBRA coverage.

If your company is subject to the COBRA requirements, you must have a separate group identification number for COBRA eligible employees/covered dependents selecting HAP. Contact your Sales Representative if you do not have a separate group established. When a qualifying event occurs, and the employee/covered dependent selects COBRA, they must be moved to the COBRA segment.

COBRA Eligibility
When an employee has a COBRA qualifying event, you are required to notify HAP within thirty (30) days on the Membership and Record Change Form in the section called “Remove Members from Policy (Deletions)”; or Electronic Data Interchange (EDI); Internet access; or a hard-copy report (Excel spreadsheet, etc.) from you.

- Remove the employee/covered dependent from your regular plan.
- If the beneficiary elects COBRA coverage, use the day after the cancellation date as the effective date for COBRA coverage.

Note: A lapse between group coverage and coverage through COBRA is not permitted for any reason.
Conversion Coverage
When employees/covered dependents are no longer eligible for coverage through their plan, they may be eligible for a group conversion plan. The conversion plan may be selected as an alternative to COBRA continuation, or after coverage through COBRA ends.

| Alliance EPO/PPO | Employees should contact Celtic Insurance Company toll-free at (800) 365-2365 for an explanation of their Medical Expense Conversion Program. Celtic offers continuation coverage for disenrolling Alliance members outside the HAP service area.
| --- | --- |
| HAP HMO | Employees should contact the HAP Client Services Department toll-free at (800) 422-4641 for an explanation of Group Conversion benefits and costs.
For residents outside the HAP service area contact Celtic Insurance Company toll-free at (800) 365-2365 for an explanation of their Medical Expense Conversion Program. Celtic offers continuation coverage for disenrolling HMO members outside the HAP service area.

Group Reference #10F406000

IMPORTANT: COBRA beneficiaries whose coverage is cancelled for nonpayment are not eligible for Group Conversion coverage.

Medicare Group Retiree Plans, HAP Senior Plus and Alliance Medicare PPO Plans

Overview
This section of your manual pertains only to retirees and dependents who are Medicare eligible and offered coverage through either of the above Medicare plans through HAP. Coverage for retirees and dependents who are not Medicare eligible will be addressed in the relevant product section of this manual, and in your Contract with HAP.

HAP Senior Plus and Alliance Medicare PPO plans are each offered through a Medicare contract between Health Alliance Plan (HAP) and the federal Medicare program (Centers for Medicare and Medicaid Services or CMS). In this program, Medicare beneficiaries retain their rights under Medicare, though their covered services are provided in full by the plan (HAP).

The federal Medicare program views Medicare beneficiaries as individuals and many of its requirements are designed to protect the rights of those beneficiaries. Requirements may differ for individual coverage from policies an employer group sponsors for its Medicare retirees, although there are still Medicare-specific requirements that must be met.

Complementary Members
Group Retiree Plans are offered to eligible members who:
- Live in the HAP approved service area
- Must be enrolled in Medicare Parts A and B
Eligibility/Enrollment - Medicare Requirements
Each new eligible retiree should be offered the option of selecting one of the plans at the time of retirement and during the open enrollment period(s). Medicare will accept and process an enrollment for someone newly eligible to Medicare any time during the three (3) months prior to, the month of, and three (3) months after the birth date (for beneficiaries eligible because of age).

★HAP is proud to share the news:
  • Medicare has awarded the highest Medicare Star Ratings in Michigan for 2011 to:
    HMO: HAP Senior Plus (hmo)
    HMO-POS: HAP Senior Plus (hmo-pos)
    PPO: Alliance Medicare PPO*

*Based on the 2011 Medicare Overall Plan Star Ratings. See full results at [www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan).

In order to enroll, retirees must:
  • Live in the HAP approved service area
  • Be enrolled in Medicare Parts A and B
  • Comply with the CMS guidelines established with your group regarding end-stage renal disease (ESRD)**

Each retiree or covered dependent must qualify for coverage individually under his/her own Medicare claim number.

Enrollment procedures must follow the CMS-established guidelines for paper or electronic submission. HAP will provide a group enrollment form with the required data elements, if you choose the paper method. The form must be reviewed for completeness and submitted to HAP for processing.

Enrollments are effective the first of the month following the ‘effective’ signature date from the retiree. The effective signature date is the date upon which the retiree makes his/her election known. This date is communicated in the manner and timing established in the contract between you and HAP.
Medicare has strict rules about when, and under what conditions Medicare beneficiaries may enroll or disenroll and the dates by which those transactions have to be received. This is not up to the discretion of the health plan or the plan sponsor. Medicare ultimately approves or disapproves the request. In addition, Medicare is not supportive if it sees consistent patterns of requests that do not meet its rules:

1. Generally, a beneficiary can enroll effective the 1st of the following month if the health plan receives a complete application by the last day of the prior month. A member wishing to enroll September 1st, for example, must submit a complete and accurate application to the plan by, at the latest, August 31st. This enrollment date would be allowed even if the plan sponsor does not submit the information to HAP until up to 60 days after the requested effective date. What is critical is the date the applicant signed the enrollment form or authorized the enrollment.

2. Generally, a beneficiary can disenroll effective the 1st of the month. So if a beneficiary wanted to disenroll from a Medicare Advantage plan effective September 1st, the member would have to request the change by August 31st.

3. Exceptions to the above two rules are rare, and require submission of a member-specific case file explaining to the Medicare program what special circumstances warranted the exception. Medicare ultimately has the right to accept or deny the request. Generally, cases accepted favor the member if the member could not have understood the implications of enrolling in the plan (example: the member has Alzheimer’s disease). These reviews generally take time for Medicare to complete its review and make a decision.

4. In the unusual circumstance where Medicare allows a retroactive disenrollment, then all claims involved have to be resubmitted to Medicare for reprocessing.

Medicare allows retroactive enrollment and/or disenrollment of up to three (3) months from the date HAP receives the appropriate notification, but only if the actual date signed by the retiree was before the date being requested.

Please indicate if the basis for the disenrollment is loss of eligibility. If the reason for the disenrollment request is due to death of the member, please note this so that HAP may issue the most appropriate notification required by Medicare.

** Please contact your Sales Representative for the specifics of the Contract between your group and HAP. **