Welcome to the Plan Where You Belong

2017 | Individual and family plans
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Detailed information on specific plans can be found at the back of this document. If you would like to know about other plans, contact a knowledgeable, certified HAP Personal Alliance representative at (888) 909-4707 (TTY: 711). You can also visit hap.org/plans.
Why Choose HAP?

We believe a health plan should be more than doctors and deductibles. It should be a trusted resource – there when you need it. With HAP, you’ll find exactly that: a place that feels like home, protects your health and makes you feel welcome at every turn. We offer personal care and prompt customer service – and, of course, excellent coverage from a large network of doctors and specialists.

HAP offers HMO and PPO plans to meet your needs. So whether you’re considering HAP Personal Alliance® for the first time or you’re a current member looking to change plans, HAP has something for you.

Welcome to peace. Welcome to HAP.

Dedicated personal service

You can tell how much your friends truly care by the little things they do to help. Why should it be any different with a health plan? It shouldn’t. This is why HAP Personal Alliance offers you extra perks to make it easier to use your health plan.

To make sure our relationship gets off to a healthy start, we assign you a personal service coordinator for the first two years of your membership. You’ll have one person to help answer any of your questions, find solutions for you and guide you along the way.

Your personal service coordinator will contact you following enrollment to make sure you’ve received your benefit information, verify the enrollment process was a good one and help you get started taking your health assessment in your member portal. We’ll do all that and happily answer any questions you may have at that time. No other health plan does this.

Emergency and urgent care at home and around the world

HAP provides peace of mind in emergency situations around the world.

- Emergency services – Whenever an emergency situation arises (broken bone, chest pains, difficulty breathing, severe burn, etc.), HAP members are covered at any emergency room, anywhere in the world.
• **Urgent care** – HAP-affiliated urgent care centers in Michigan are equipped to handle issues that aren’t life threatening, such as sprains, cuts that require stitches, minor burns, back pain, the flu and more. In addition, visiting an urgent care center could save you time and money. To find an urgent care center, visit [hap.org/doctors](http://hap.org/doctors). HAP plans also cover urgent care services anywhere in the world, giving peace of mind to members while they travel.

• **Global emergency services** – Be worry-free knowing HAP provides Assist America and its global emergency services when you’re more than 100 miles away from home or in another country for no more than 90 days in a row. HAP works with Assist America to help you find the right hospital, replace lost or left-behind prescriptions, provide lost luggage assistance, recommend translation services and more.

   All services are provided, arranged and paid for by Assist America without limits on the covered cost. HAP members can access Assist America through HAP’s mobile app, HAP OnTheGo. The Assist America call center is fully staffed 24/7 to serve you whenever you need it, wherever you are located.

• **Identity theft protection services** – Assist America offers identity theft protection free for HAP members. Identity theft protection provides professional fraud support 24/7 and offers the right tools to safeguard personal data and credit history.

**Students Away at School program (HMO plans only)**

In addition to worldwide emergency and urgent care, students who are ages 5 to 26 and away at school are covered for a number of common services (with prior authorization), including:

- Required maintenance visits for chronic conditions
- Allergy injections
- Prescription coverage (as allowed under the member’s medication rider)
- Routine immunizations
- Acute illness or injury:
  - Follow-up office visits
  - Outpatient imaging and laboratory tests
  - Physical therapy for rehabilitation
  - Durable medical equipment (with DME and Prosthetics & Orthotics rider)

The following services are **NOT** covered under the Students Away at School program:

- Routine physical exams
- Routine gynecology exams
- Elective surgery or hospitalizations
- OB-GYN services for pregnancy
- Doctor visits and physical therapy, outpatient therapy, or other therapies or treatments that don’t have prior authorization
- Vaccines administered for the sole purpose of travel

Note: We do not cover dependent children who live with a custodial parent outside of our service area under the Students Away at School program.

Visit [hap.org/studentsaway](http://hap.org/studentsaway) for more information about the Students Away at School program.
Cost carryover benefit

When you become a member, your health care costs from a previous plan will carry over to a new HAP health plan within the same calendar year. These are costs you already paid out of pocket for covered services, medications and medical supplies.

Only HAP lets you carry over out-of-pocket costs to a new health plan.

The out-of-pocket limit (OOPL)* is the most you would pay for covered services during a benefit period (usually a calendar year). Once you meet your out-of-pocket limit with HAP, we pay all of the allowed amount for covered services. The faster you meet your limit, the faster HAP begins to pay 100 percent of allowed amounts for covered services.

Example:

John had coverage through a competitor’s health plan until recently. His plan included:

- $2,000 deductible
- $20 generic drug copay
- 20 percent coinsurance
- $4,500 out-of-pocket limit

In January, John injured his knee playing hockey and had the following out-of-pocket costs on covered services and prescriptions with his old health plan:

- $2,000 toward surgery (met his deductible)
- $80 in drug copays
- $250 coinsurance for a follow-up MRI

Total out-of-pocket costs: $2,330

When John made the switch, his new HAP PPO plan had the following:

- $2,000 deductible
- $20 generic drug copay
- 20 percent coinsurance
- $4,500 out-of-pocket limit

In this example, John was able to carry over the entire $2,330 from his old plan, which helped him satisfy over half of the out-of-pocket limit of his new HAP health plan.

With the HAP carryover benefit, John’s deductible is now considered to be met.

*The out-of-pocket limit never includes your monthly premium, noncovered prescriptions, or noncovered medical services and devices. This process does not include out-of-network costs.
**HAP extra benefits, services and support**

Providing you with a quality health care plan is just the beginning. HAP goes beyond with extras that make getting and staying healthier easier, faster and hassle free.

**Supportive care management**

HAP continually strives to ensure that you receive care and all necessary services when you need it most. Our care management team helps to deliver that promise.

**HAP Restore Case Management program**

HAP Restore is a free program that assists members who need intensely focused care coordination due to complex conditions and those transitioning from one care setting to another. As a participant in the program, you’ll have a registered nurse who cares about you, your condition and your treatment plan. Your HAP nurse will work closely with you and your doctor to make sure you’re getting the care you need, when you need it. Your nurse will be there to help you with:

- Scheduling visits with specialists and treatment facilities
- Gaining a full understanding of your condition
- Understanding and managing your medications
- Working with your doctor to schedule home visits with registered nurses and therapists when you need them
- Making sure you get the equipment you need
- Connecting you to community resources that can assist with basic everyday needs
HAP Restore Caretrack® disease management program

We offer a comprehensive disease management program for those who have been diagnosed with a chronic condition. The program can help you stick to your doctor’s prescribed treatment plans and provides you with a nurse health coach who will work with you over the phone to meet your goals.

Some of the conditions this program can help manage are:

- Asthma
- Diabetes
- Heart failure
- Heart disease
- Chronic obstructive pulmonary disease

Utilization management

Another way we ensure you get the right care in the right setting for the right length of time is through utilization management processes. We do this by using different review processes (pre-service, urgent concurrent and post-service) at different stages of your care. Utilization management employs proven medical practices from doctors across the country.

All utilization management decisions are based only on the appropriateness of care and service and the existence of coverage. We don’t specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. HAP doesn’t offer financial incentives to deny services.

If you have questions about these review processes, please call us at (888) 999-4347.
Perks beyond health care

We believe you deserve every advantage possible to keep yourself in the best health.

Health and weight management services

HAP gives you tools and programs to help you take control of your health.

- **Weight Watchers®** – As part of HAP’s commitment to healthy living and preventive care, you can join Weight Watchers for a discounted rate, and HAP will pay the rest of the enrollment fee.

- **iStrive® for Better Health** – Our digital wellness manager starts with iStrive, an online health assessment tool. With iStrive, you can create a customized plan and access strategies designed by health care professionals to help you make healthy choices, overcome pitfalls and achieve your goals. Once you’re a member, you can log in at [hap.org](http://hap.org) and go to the iStrive digital wellness manager for more information.

HAP Advantage discount program

You’ll have access to a variety of health and wellness related discounts such as gym memberships, weight loss programs and more. Many HAP Advantage partners are local companies and venues that call Michigan home, just like you do.* For a complete list, visit [hap.org/discounts](http://hap.org/discounts).

### New for 2017

In 2017, HAP members will have 24/7 access to a doctor using a computer, tablet or smartphone through our new **Telehealth Services** program.

We’re also planning to roll out our new **Health Care Cost Estimator**. Members can log in to [hap.org](http://hap.org) and use the estimator to search for cost estimates by medical condition or procedure and compare costs between facilities. They can even get estimated out-of-pocket costs for certain health services or treatment based on their HAP health plan.

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*The HAP Advantage discount program is a value-added program, and the services and products made available under this program are not covered benefits under the Health Alliance Plan (HAP) or Alliance policy, riders, or member handbook or otherwise payable by HAP or Alliance. HAP or Alliance, its affiliates, agents and assigns make no representations or warranties regarding the quality, price or effectiveness of the services or products, or the credentialing of the providers, made available by HAP Advantage discount.*
Our Family of Health Plans

HAP offers a variety of HMO and PPO plans to fit your particular budget and a wide network of leading doctors and hospitals to choose from. Members must reside within the service area of the plan in which they enroll to maintain active coverage in that plan.

About HMOs and PPOs

Health Maintenance Organizations, or HMOs, and Preferred Provider Organizations, or PPOs, are two types of managed care plans. Both plans are designed to reduce health care costs by focusing on preventive care and utilization management. It’s important to understand the differences between these two types of plans, because choosing between them is one of the most important decisions you’ll need to make when selecting a health plan.

HMO

HMO plans tend to be more affordable. You need to select a primary care physician from an established network of providers who will manage and track your health care services. When you need to see a specialist, your PCP will coordinate care. Our system of paperless referrals makes the process quick and hassle-free.

Benefits:

- HMO members are free to choose and change their PCP as often as they wish. Each family member may choose a different PCP
- Members have access to the leading providers and hospitals within their chosen network
- Worldwide emergency and urgent care coverage

To locate a doctor, visit hap.org/doctors, or you can call the PCP hotline at (888) 742-2727.
HMO service area network

You can purchase HAP HMO health plans if you live in any of the following 18 counties: Arenac, Bay, Genesee, Huron, Iosco, Jackson,* Lapeer, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne. Once you’re an HMO member, you can receive services from doctors and medical facilities within these 18 counties.

Choice HMO networks

Both of our Choice HMO network options offer you all the benefits of an HMO along with great HAP coverage, lower premiums and prompt, personal service. And by narrowing the network of providers and medical facilities, you can save up to 25 percent on the premiums.

Henry Ford Choice network

The Henry Ford Choice network offers world-class care from a nationally recognized health system known for its clinical excellence and medical research. It includes nearly 5,000 doctors within the Henry Ford Health System. The network includes Macomb, Oakland and Wayne counties, with the exception of the following Oakland County ZIP codes: 48346, 48348, 48350, 48353, 48356, 48357, 48359, 48360, 48362, 48367, 48370, 48371, 48428, 48430, 48439, 48442, 48455 and 48462.

Genesys Choice network

The Genesys Choice network is available to Michigan residents in Genesee County and gives you access to the leading mid-Michigan doctors and specialists within Genesys Physician Hospital Organization and facilities that are part of the Genesys Regional Medical Center. They have a mission and history of improving the community’s health for more than 90 years.

*Coverage in Jackson County will be effective Jan. 1, 2017, for HAP Personal Alliance customers (pending state approval).
A PPO offers you more choice and flexibility. You don’t need to select a PCP, and you can seek care from providers either within or outside of the network without referrals. This type of health plan offers a wide range of benefit options that include incentives such as reduced out-of-pocket costs when you seek care from network providers. HAP Personal Alliance offers several PPO health plans, with varying deductibles to fit any budget.

PPO service area network

You can purchase Personal Alliance PPO health plans if you live in any of the following 21 counties: Arenac, Bay, Genesee, Gratiot, Huron, Iosco, Jackson, Lapeer, Livingston, Macomb, Monroe, Oakland, Ogemaw, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne. Once you’re a PPO member, you can receive services from doctors and medical facilities throughout HAP’s entire statewide network.

Understanding your plan and its costs

When comparing HAP plans, it’s helpful to know the basics about health plans and how benefits and costs are structured. Every health plan is unique, and your specific benefits and costs may differ depending on the plan you choose.

Categories of Essential Health Benefits

Essential Health Benefits (EHBs) are categories of health care services that must be covered by all Qualified Health Plans (QHPs), and HAP is no exception. EHBs include the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

*Coverage in Jackson County will be effective Jan. 1, 2017, for HAP Personal Alliance customers (pending state approval).
Categories of health plan cost levels and metal tiers

Health plans are grouped into categories called metal tiers. The idea behind metal tiers is to allow you to compare health plans with similar coverage value. HAP offers plans in the Gold, Silver and Bronze tiers. Each tier shows how you and your plan share costs. The amount you pay for covered services, medications and medical supplies is called cost sharing.

Qualified health plans are grouped in different metal tiers based on the percentage of health care costs the plan covers. Bronze health plans usually have the lowest monthly premiums and highest out-of-pocket costs – copays, deductibles and coinsurance – while Gold health plans usually have higher monthly premiums and lower out-of-pocket costs.

As premiums increase, out-of-pocket costs decrease:

<table>
<thead>
<tr>
<th>Metal Tier</th>
<th>Monthly premium</th>
<th>Out-of-pocket costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td>$$$</td>
<td>$</td>
</tr>
<tr>
<td>Silver</td>
<td>$</td>
<td>$$$</td>
</tr>
<tr>
<td>Bronze</td>
<td>$</td>
<td>$$$$$</td>
</tr>
</tbody>
</table>

HAP also offers Catastrophic plans. Catastrophic plans offer coverage for higher-cost services such as hospitalization. This type of plan is available to individuals who are under 30 or who receive a hardship exemption from the government.
Understanding your cost sharing

When comparing health plan costs, you need to look beyond the monthly premium. As a health plan member, you’re required to share the cost of services covered by your insurance through deductibles, copays and coinsurance. These are called your out-of-pocket costs. They don’t include premiums, charges above HAP’s approved amount or the cost of noncovered services.

Once you meet your in-network, out-of-pocket limit, you don’t need to pay for covered or approved in-network services for the remainder of that calendar year.

Copay

A set amount you pay each time for a covered service or the purchase of medications or other medical supplies. The copay amount can vary by the type of covered health care service. Typically copays don’t count toward the deductible. You will continue to pay copays after you have met your deductible, until reaching your out-of-pocket limit.

Deductible

The amount you owe for certain covered medical services before your health plan begins to pay for them. There are individual deductible amounts and family deductible amounts.

Coinsurance

The percentage of charges for certain covered services that you pay after your deductible has been met.

Out-of-pocket limit

The most you pay for covered services during a benefit period (usually a calendar year) before HAP begins to pay 100 percent of the allowed amount. All copays, coinsurance and deductible amounts count toward your out-of-pocket limit. Your monthly premium and noncovered services don’t count toward your out-of-pocket limit.
Plan deductibles

All HAP plans have individual deductibles as well as family deductibles. Family deductibles can work differently depending on the type of plan you have.

Most 2017 HAP plans have embedded family deductibles. However, if your plan has HSA in the name, it is a qualified high-deductible health plan that can be paired with a health savings account (HSA). These plans have an aggregate deductible or an aggregate with a cap deductible. Aggregate deductibles are handled differently, which can impact how you meet your family’s out-of-pocket limits.

Types of family deductibles

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>What does this mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded</td>
<td>For family coverage, there are two different deductibles: individual deductibles and the family deductible.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Individual deductibles</strong>: When any family member meets their individual deductible limit, HAP will begin paying the entire amount for covered services for that specific member.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Family deductible</strong>: When the family collectively meets the family deductible, services for all family members are covered – even family members that have not met their individual deductible.</td>
</tr>
<tr>
<td>Aggregate</td>
<td>For family coverage, there are no individual deductibles. All family members work together to meet the family deductible.</td>
</tr>
<tr>
<td></td>
<td>• The deductible can be met by a single family member or the combination of multiple family members.</td>
</tr>
<tr>
<td></td>
<td>• As soon as the family deductible is met, services for all family members are covered.</td>
</tr>
<tr>
<td>Aggregate with a cap</td>
<td>For family coverage, there are no individual deductibles. All family members work together to meet the family deductible. <strong>However, each family member has a cap, or out-of-pocket limit.</strong></td>
</tr>
<tr>
<td></td>
<td>• A family member’s OOPL is the most that person can contribute toward the family deductible.</td>
</tr>
</tbody>
</table>
Out-of-pocket limits

An out-of-pocket limit is the most you will pay for covered services in a calendar year. All copays, coinsurance and deductible amounts count toward your out-of-pocket limit. HAP plans have both an individual OOPL and a family OOPL. HAP plans can have either an **embedded** or **aggregate** out-of-pocket limit; most 2017 Personal Alliance plans have **embedded** family OOPLs.

Types of family out-of-pocket limits

<table>
<thead>
<tr>
<th>Out-of-pocket limit type</th>
<th>What does this mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Embedded</strong></td>
<td>For family coverage, the most any one person in the family will pay toward the OOPL is their individual OOPL.</td>
</tr>
<tr>
<td></td>
<td>• Once a family member meets their individual OOPL, HAP pays the entire allowed amount of that specific member’s covered services for the rest of the benefit period.</td>
</tr>
<tr>
<td></td>
<td>• Once the family collectively meets the family OOPL, HAP pays the entire allowed amount for covered services for all family members for the rest of the benefit period.</td>
</tr>
<tr>
<td><strong>Aggregate</strong></td>
<td>For family coverage, the family OOPL is the maximum combined amount all family members will pay in copays, coinsurance and deductible amounts.</td>
</tr>
<tr>
<td></td>
<td>• The family OOPL can be met by one family member or by several family members.</td>
</tr>
<tr>
<td></td>
<td>• As soon as the family OOPL is met, HAP pays the entire allowed amount for covered services for all family members for the rest of the benefit period.</td>
</tr>
</tbody>
</table>

Watch the video at hap.org/madesimple to better understand how cost sharing, deductibles and OOPLs work.

If you’d like to have someone walk you through the different scenarios to understand the differences, talk to your agent or speak directly with a knowledgeable, certified HAP Personal Alliance representative by calling us at **(888) 909-4707**.
What’s a health savings account?

We offer health plans that can be paired with a health savings account, or HSA, to maximize your benefits. An HSA is a personally owned bank account for medical expenses for those enrolled in a qualified high-deductible health plan. You can use your HSA to pay for your health care costs, from doctor and hospital visits to copays, eyeglasses and prescriptions. Covered health care costs paid from an HSA can be applied toward meeting the annual health plan deductible. Any unused funds in your HSA will roll over annually. The funds contributed to the account aren’t subject to federal income tax at the time of deposit. To take advantage of an HSA, you need to select, set up and fund an HSA with a qualified financial institution, like a bank or credit union.

HSA benefits

Triple tax savings

1. Contributions are made with pretax dollars
2. The interest you earn on your HSA balance isn’t taxed
3. Withdrawals from your HSA for qualified medical expenses aren’t subject to federal or state income tax

Flexibility

1. The money grows and stays with you, even when you change health plans or retire – and even if you’re no longer eligible to make contributions
2. As long as you’re covered by a qualified high-deductible health plan, you, your family members or anyone else may contribute to your HSA, up to the maximum annual contribution limit

HAP Personal Alliance offers a variety of federally qualified high-deductible health plans to pair with an HSA. These plans can help you save for future health care expenses. Funds over $1,000 can even be invested in various mutual funds. Our trusted partner, BenefitWallet™, is one of the leading HSA administrators in the nation. Of course, you can choose to open an account at another bank or credit union, too. After enrolling and upon approval of your HAP plan, BenefitWallet will send a welcome kit within seven to 10 business days. This kit will have all the necessary instructions, including how to activate the HSA account. The amount that you can contribute annually to your HSA is defined by the government and can increase each year.
Prescription drug coverage

HAP provides a list of covered drugs (formulary), along with the copay amount for each. View and learn more about HAP’s Drug Formulary by clicking on the Qualified Health Plan formulary at hap.org/prescriptions. Outpatient prescription benefits are listed by copays based on the drug tier.

Some covered drugs have requirements or limits. These requirements are listed on the formulary and may include:

- **Prior authorization** – With prior authorization, you’ll need to get approval from HAP before your prescription is filled.

- **Step therapy** – In some cases, HAP may require you to first try a certain drug to treat your condition before another drug is covered.

- **Quantity limits** – Certain drugs have quantity limits.

- **Pharmacies** – Prescriptions must be filled at HAP-contracted pharmacies. To find one, visit hap.org/prescriptions.

**Tier 1 Drugs (generic)**

These are drugs that are approved by the Food and Drug Administration. They have the same active ingredients and strength as brand-name drugs.

**Tier 2 Drugs (preferred brand)**

These are drugs approved by the FDA. They are designated by HAP as preferred brands. They meet the quality, safety and cost standards that can be consistent with our benefit, referral and practice policies.

**Tier 3 Drugs (nonpreferred brand)**

These are brand drugs that are approved by the FDA. They’re not included as generic drugs or preferred brand drugs on our formulary.

**Tier 4 Drugs (specialty)**

These drugs are approved by the FDA and are designated by HAP as specialty drugs. They’re used to treat complex and/or chronic illnesses. They require close supervision. They include injectable/infusible and certain oral and inhaled drugs. They require prior authorization from HAP. To ensure safety and quality care, these drugs must be filled at a HAP-contracted specialty pharmacy.

*There are select plans that include a medical or separate drug deductible that must be met before copays or coinsurance applies. Please refer to the Schedule of Benefits charts located at the back of the brochure.*
Medical drugs and mail order

Medical drugs

Medical drugs, when given in a health care facility or a physician’s office, are considered a medical benefit. These drugs can also be dispensed by a home infusion pharmacy for infusion in the home, and coinsurance may apply. Check your health plan benefits for cost sharing details about your medical drug coverage.

Mail-order service and specialty provider service

HAP offers mail-order pharmacy services through Pharmacy Advantage, our contracted mail order provider. You can get up to a 90-day supply of some medications (new prescriptions or a simple refill). This saves time and money and eliminates trips to the pharmacy. HAP offers specialty pharmacy services through Pharmacy Advantage, our contracted specialty provider. You’re required to fill your specialty medications through Pharmacy Advantage.

Dental benefits

When you’re considering a health plan, don’t forget about your smile. Dental care is important. Minor oral health problems, left untreated, can lead to more serious health problems – which can affect your overall health. Dental care can also be very expensive without insurance. Fortunately, pediatric dental is one of the 10 essential health benefits which is required for members 18 and younger.

Delta Dental®

If you purchase a HAP health plan and haven’t or don’t plan on purchasing dental benefits from a Marketplace-certified stand-alone dental carrier, you must choose from one of these Delta Dental options:

- Pediatric dental coverage
- Pediatric and adult dental coverage

Adults without children will be charged a $0 pediatric plan premium and will be provided with the needed evidence of EHB compliance from Delta Dental.

A quality dental plan from Delta Dental can help you get the care you need to stay healthy. You can search for an affiliated dentist at deltadentalmi.com.
**Vision benefits**

We’re proud to offer our members top-notch coverage for eye care. All HAP plans include an annual eye exam at no additional cost, from a vast network of highly skilled professionals providing the full spectrum of quality eye care for the whole family. These include:

- Henry Ford OptimEyes™
- SVS Vision Optical Centers
- Co/Op Optical
- Family Eye Care Associates
- Fraser Optical®
- Northwest Eye Physicians
- Rx Optical®

Visit hap.org/doctors for a complete list of the eye care professionals in our network.

**Pediatric vision benefits**

HAP has your vision benefits covered. One of the 10 essential health benefits is pediatric vision care, for those members 18 and younger. All HAP qualified health plans include a routine annual eye exam. Pediatric members also receive vision hardware coverage.

**Pediatric vision hardware benefits**

- One pair of eyeglasses every calendar year
- One pair of lenses every calendar year, including: your choice of single-vision, conventional bifocal or trifocal, or lenticular lenses; your choice of glass, plastic or polycarbonate lenses; fashion or gradient tinting; regular or oversized; scratch-resistant coating; and glass grey #3 prescription sunglasses (all covered with no cost sharing)
- Contact lenses once every calendar year in lieu of eyeglasses
- Wide selection of designated collection frames and contact lenses
Things to Know Before You Enroll

Enrollment guidelines and eligibility

You’re able to apply or change health plans only during the open enrollment period each year unless you qualify for a special enrollment period.

Open enrollment period

Whether you’re considering HAP Personal Alliance for the first time or you’re a current HAP member looking for other plan options, HAP has a plan for you. To enroll in a HAP health plan talk to your agent, or speak directly with a knowledgeable, certified HAP Personal Alliance representative by calling us at (888) 909-4707 or visit hap.org/plans.


Special enrollment period

Certain life events may qualify you to enroll in a qualified health plan outside of open enrollment, which is called a special enrollment period.

A special enrollment period can be approved for qualifying life events that allow you to change an existing qualified health plan or sign up for a new health plan within 60 days of the event.

Please note, documented proof of the qualifying event must be included with the application.

Qualifying life events include, but aren’t limited to:

- Changes in family size (if you marry, divorce or have a baby, etc.)
- Loss of coverage
- Relocating to a new area
- Certain changes in income

To submit an application for a special enrollment period, talk to your agent or speak directly with a knowledgeable, certified HAP Personal Alliance representative by calling us at (888) 909-4707 or visit hap.org/plans.
Eligibility under the Affordable Care Act

The Affordable Care Act was designed to improve access to health care for everyone. Under the ACA, you cannot be denied coverage or pay a higher rate based on a pre-existing medical condition. If you currently don’t have coverage through an employer health plan, Medicare or Medicaid, you’ll have to get it on your own or face a tax penalty. There are other types of coverage that may also satisfy this mandate such as the Children’s Health Insurance Program, Veterans Affairs, the Indian Health Service or TRICARE.

Our ACA toolkit has valuable information about how to get a lower cost health plan, the types of plans that you can purchase and what they cover, as well as how to prepare for enrollment. Download your toolkit at choosehap.org/health-care-reform.

Medicare

Medicare is the federal health insurance program for people who are 65 or older, under 65 with certain disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

If you’re currently enrolled in Medicare, you’re not eligible to enroll in a HAP Personal Alliance health plan, but HAP may still have the right plan for you. Visit hap.org/medicare to see Medicare plan options that may be right for you.

Medicaid

Medicaid is a state-administered health insurance program for low-income families and children, pregnant women, the elderly and people with disabilities.

Medicaid coverage may provide cost sharing or lower premiums than ACA plans found on the Marketplace. Those who receive Medicaid aren’t eligible to receive subsidies for ACA plans.

If you’re not eligible for traditional Medicaid, you may be eligible for the Healthy Michigan Plan through HAP Midwest, if you live in certain counties. Visit michigan.gov/healthymiplan for more information.
Checklist for enrollment

Get ready for enrollment by following these steps or ask a HAP representative to walk you through the process.

1. Visit hap.org/plans and review your health plan options or determine if your current health plan still meets your needs.

2. Learn about your coverage, how your plan works and how much you might have to pay to use your plan (e.g., premiums, deductibles, copays, coinsurance, etc.).

3. Write down a list of questions.

4. Gather basic information about your household, such as:
   - Number of people in your family who need coverage
   - Monthly household income
   - Personal information on each person to be covered (date of birth, Social Security number, etc.)

5. Set a budget and know how much you can afford to spend every month on health care, both monthly premiums and out-of-pocket costs.

6. Have a go-to doctor in mind for you and members of your family who will be covered under the plan. If you’re enrolling in an HMO plan, you’ll need to select a primary care physician or one will be assigned for you.

7. Make a list of any medications you or your family members take so you can check if those medications are covered in the health plan’s drug formulary. To view HAP’s Drug Formulary, visit hap.org/prescriptions.

8. Gather the required proof of the qualifying life event if you’re enrolling due to a special enrollment period. Qualifying life events include, but aren’t limited to:
   - Changes in family size (if you marry, divorce or have a baby, etc.)
   - Loss of coverage
   - Relocating to a new area
   - Certain changes in income

Visit hap.org/plans to shop for plans.
Buying coverage

There are several ways to buy a health plan. You can purchase one through insurance companies like HAP, through a HAP appointed agent or through the Health Insurance Marketplace.

Through HAP

• You can purchase a health plan for individuals and families directly from HAP by calling our certified experts at (888) 909-4707 who can assist with selecting a plan that meets your needs.

• You can enroll in a Marketplace plan through HAP by calling our experts at the number above.

• You can purchase HAP coverage through a HAP-appointed agent.

Get informed at hap.org/plans. Our website includes a comprehensive set of tools that can assist in finding the right plan for you and your family.

• Get help choosing a plan

• Estimate plan costs

• Find out if you qualify for a premium subsidy

Or speak directly with a knowledgeable, certified HAP Personal Alliance representative by calling us at (888) 909-4707.
Once You’re a HAP Member

Online tools available on the HAP member portal

As a member, you can manage details of your health plan at hap.org. Once registered, you’ll have 24/7 access to free, secure, digital self-service tools. In your personalized member portal you can:

- Get 24/7 online access to a doctor through our Telehealth Services program — new for 2017!
- Search medical cost estimates and compare facility costs with the Health Care Cost Estimator — new for 2017!
- View important plan documents such as contracts, policies, riders, and your Summary of Benefits and Coverage
- Find out what’s covered and your out-of-pocket costs
- Search our list of doctors
- View your claim summary, claim history and Explanation of Benefits
- Look up a prescription drug on our formulary of covered drugs
- Send and receive secure messages
- Register for a member-exclusive health and wellness event
- View your health reminders to track when you’re due for preventive services
- Check out iStrive® for Better Health, your free digital wellness manager, and take an interactive health assessment
- Sign up for paperless options
- Pay your premium online
Mobile apps

- **HAP OnTheGo** – It’s easy to find a doctor or nearby health care facility, download an ID card, check symptoms and manage health conditions.

- **Assist America** – Get immediate access to global emergency assistance when traveling. Call the Assist America Operations Center from anywhere in the world with the touch of a button. Assist America also offers Identity Theft Protection Services free for HAP members, which provides professional fraud support 24/7.

- **Catamaran Pharmacy Benefit** – Manage your prescriptions anywhere. You can price medications, view medication history, locate a pharmacy and research drug information. Catamaran is available for HAP members as an app or online tool.

All three mobile apps are available in iOS or Android versions.
Initial premium payment

Your initial payment is very important and must be received and processed prior to the effective date of coverage. The government requires that all insurance carriers, including HAP, cancel coverage for members who don’t meet this payment requirement. Once the first premium payment is made, late payment can result in a delinquency of the account. Please refer to page 29 for more details.

Payment processing

Electronic payments are processed on or around the 26th of every month. If the payment processing date falls on a weekend or holiday, then the payment will be withdrawn on the next business day immediately following the weekend or holiday.

For members who are enrolling as a result of a special enrollment period, new payment rules apply. The effective date of coverage and the due date of your initial payment and ongoing payments may vary. If the effective date of coverage is prior to the date your application was submitted and approved, according to government guidelines, multiple months’ premiums may be withdrawn at the same time.

Credit, debit or EFT

If you choose to pay using credit, debit or EFT at the time of application, the first payment will be automatically withdrawn based on your chosen payment method. You can also set up recurring payments at this time. An email will be sent once the payment is successfully withdrawn from your account.

Bill Me Option

If you choose the Bill Me Option at the time of application, payment must be received and processed prior to the due date on the bill in order to avoid cancellation and to continue to have active coverage and access your benefits. Please allow ample time for mail delivery and processing to ensure that your payment is posted to your account on time. Please be sure to include the payment coupon at the bottom of the invoice with your payment.

Payment options

When purchasing a plan, you can use the following ways to pay your premiums, including your initial payment:

- Electronic Funds Transfer
- Credit and debit cards
- Bill Me Option (This option will allow you to select a paper bill at the time of enrollment instead of having to pay with a credit card or checking account)

Managing your HAP health plan

Payment and self-service options

HAP makes it convenient to purchase and pay for your plan, as well as make changes to your payment options, through our Bill Pay tool.
If your account doesn’t have sufficient funds available to pay for your coverage, contact HAP Customer Service at (888) 735-2542 to correct the situation. HAP isn’t responsible for any related charges that you may incur with your financial institution.

Self-service options

We offer our members options in making changes to their payment information. You can contact us for assistance, or use our member portal.

Online payment tool

Once you’re a member, you can register at hap.org to access valuable member information as well as manage your account through our 24/7 bill pay. You’ll be able to:

- Manage and change your method of payment (credit card, debit card or EFT)
- Update credit card or banking information
- Set up automatic monthly payments
- Make a one-time payment
- Request a paper invoice to be mailed to you
- View your online payment history

To pay your bill online:

Once you’re a member, log in at hap.org using your member ID number. Click the Bill Pay icon.

All unpaid invoices will be accessible within 24 to 48 hours of registering for Bill Pay. In order for your coverage to be active as of your effective date, payment must be received prior to your due date. We’ll continue to use the payment method you set up to pay your premiums.
Precertification (for PPO health plans only)

Some services and supplies require precertification by HAP in order to be covered services under the policy.

You must notify HAP before the medical supplies are purchased, before procedures are performed or before treatment starts. If precertification is not obtained, coverage for the procedure, supply or treatment will be denied. The denial of benefits is imposed for each incidence of noncompliance. To obtain the complete and detailed list of the services and supplies requiring precertification, call the Customer Service department at (800) 944-9399.

The following general categories of services and supplies that require precertification are:

• All inpatient services. You don’t need precertification to seek care for an emergency medical condition or when urgent care is needed. Additionally, inpatient hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section don’t require precertification. However, we encourage you to notify us at least 60 days before your due date so we’re better prepared to assist you at that time
• Outpatient services
• Durable medical equipment charges over $1,500, including rentals and repairs
• Prosthetic appliance and orthotic appliance charges over $1,500
• Oral and maxillofacial services, except emergency services
• High-tech radiology examinations, including, but not limited to:
  a) Positron-emission tomography scans
  b) MRI
  c) CT scans
  d) Nuclear cardiology studies
• Selected injectable drugs
• Supplemental feeding administered via tube or IV
• Transplants and evaluations for transplants
• Genetic testing
• Clinical trials for cancer care

Limitations and exclusions

Noncovered services (this applies to all qualified health plans)

The following is a partial list of services and supplies that are generally not covered. It’s designed for convenient reference only. Consult your policy or contract for a complete list of limitations and exclusions.

• Services rendered or expenses incurred prior to your effective date of enrollment or after cancellation of coverage
• Services or benefits that aren’t expressly listed as covered services in the policy or contract
• Services for treatment of an illness or injury resulting from declared or undeclared acts of war
• Any condition for which benefits are paid, recovered or can be recovered, either by an adjudication settlement or otherwise, under any workers’ compensation, employer’s liability law or occupational disease law, even if you don’t claim those benefits
• Cosmetic services, including, but not limited to, cosmetic surgery or any of the related services, such as presurgical and postsurgical care, complications of cosmetic surgery, follow-up care and reversal or revision of cosmetic surgery, treatment of hair loss or restoration
• Experimental and investigational services, treatment, drugs, devices or procedures
• Private-duty nursing services or residential and basic nursing services provided in a skilled nursing facility that hasn’t been prior authorized according to our benefit, referral and practice policies. Private-duty nursing should be a separate item because they’re not covered and cannot be prior authorized like the skilled nursing services.
• Dietary drugs, food and food supplements, except supplemental feedings administered via tube or intravenously
• Services provided if you’re in police custody, unless an emergency exists or such services are provided at an affiliated hospital by an affiliated provider (“affiliated” doesn’t apply to PPO plans)
• Services for any injury, illness or condition that results from or to which a contributing cause was your commission of or attempt to commit a felony or from engagement in illegal occupations
• Services and supplies not medically necessary, as defined in the policy or contact
• Charges incurred outside of the U.S. for elective care, testing, procedures, or any services other than urgent care or care for an emergency medical condition

Cancellation of coverage

Cancellation process for health plans purchased directly from HAP
To request cancellation of the entire contract, the member must submit the request in writing. If a dependent on the contract is being canceled, the request must come from the dependent if 18 years of age or older. Email your written request and reason for cancellation to hap@hap.org.

Or mail your request to:
Health Alliance Plan
2850 W. Grand Blvd.
Detroit, MI 48202

Upon canceling, if you need verification that your coverage has ended, contact Customer Service at (800) 944-9399.

Cancellation process for health plans purchased through the Health Insurance Marketplace
To cancel your plan, please work directly with the Health Insurance Marketplace at healthcare.gov.

Cancellation of coverage for nonpayment of initial premium
The initial premium payment for health plans purchased through HAP or the Health Insurance Marketplace must be received and processed prior to the effective date of coverage. The government requires that carriers cancel coverage for members who do not meet this payment requirement.

Delinquency process

Health plans purchased directly through HAP or through the Health Insurance Marketplace without premium subsidy:
The delinquency process applies after a member has paid his or her first month’s premium. If payment is not received by the due date, you won’t have access to medical or prescription benefits as of the first day of delinquency.

• You’ll be sent a notification of delinquency
• Your coverage will be terminated at the end of the first month of delinquency of nonpayment of the premium
• You’ll be liable for any medical services and charges incurred if premiums are not paid in full

Health plans available through the Health Insurance Marketplace with premium subsidy:
The Health Insurance Marketplace delinquency process applies after a member has paid his or her first month’s premium.

• Premiums for health plans purchased through the Health Insurance Marketplace are due by the designated processing date based on your effective date
• If payment isn’t received prior to the due date, and you purchased a health plan through the Health Insurance Marketplace and received a cost savings, you won’t have access to benefits after the first full month of delinquency. Prescription claims will be rejected after the last day of the first month of delinquency
• You’ll be sent a notification of delinquency.

The Health Insurance Marketplace delinquency process applies after a member has paid his or her first month’s premium.

• You’ll be sent a notification of delinquency. The Health Insurance Marketplace delinquency process applies after a member has paid his or her first month’s premium
• Your coverage will be terminated at the end of the 90-day grace period for nonpayment, provided that the member received a premium subsidy and made the initial premium payment in full
• You’ll be liable for any charges incurred if coverage is not paid in full. All premiums owed prior to the 90th day of delinquency must be paid in full, or coverage will be terminated
Glossary

Advanced premium tax credit
The amount of the monthly premium the government pays to help the taxpayer purchase health insurance; also known as cost savings. The subsidy is sometimes referred to as the APTC or premium assistance, and the amount is determined using a sliding scale based on income and family composition.

Affordable Care Act
See page 21 for more information.

Affordable coverage
As it relates to the health care reform law, employer coverage is considered affordable if the employee’s share of the annual premium for individual coverage is no greater than 9.56 percent of his or her annual household income. Individuals who are offered employer-sponsored coverage that’s affordable and provides minimum value won’t be eligible for an advanced premium tax credit.

Binder payment
Individuals purchasing health care coverage are required to pay their first month’s premium prior to their effective date of coverage. This is referred to as a binder payment. If the binder payment is not received within the specified time frame, the health insurance carrier is required by law to cancel the policy. If an individual is switching their health insurance policy to a different carrier, or if they switch to a different type of health coverage (e.g., from a PPO plan to an HMO plan) a binder payment will also be required.

Calendar year
The calendar year is January through December for Personal Alliance Qualified Health Plans.

Catastrophic health plan
A health plan that begins to pay only after you’ve first satisfied your deductible for most services. On the Health Insurance Marketplace, to qualify for a catastrophic plan, you must be under 30 years old or receive a “hardship exemption” because the Marketplace determined that you’re unable to afford health coverage.

Coinsurance
See page 12 for more information.

Copay
See page 12 for more information.

Cost sharing (also see out-of-pocket costs)
See page 12 for more information.

Deductible
See page 12 for more information.

Essential health benefits
See page 10 for more information.

Formulary
A listing of covered outpatient prescription medications established by HAP that includes generic drugs and brand-name drugs that are covered by the plan. The formulary is updated on an ongoing basis and is published on hap.org/formulary.

Health Insurance Marketplace
The Marketplace is an online resource where individual families and small businesses can learn about, compare and purchase health coverage.

HMO
See page 8 for more information.

Health savings account
See page 15 for more information.
Individual mandate

This includes health insurance coverage for individuals and families purchasing coverage on their own. People without private insurance will face tax penalties that will be phased in and increased over several years. You won’t have to pay a penalty if you don’t make enough money to file a federal tax return or if you would have to spend more than 8 percent of your household income on the least-expensive health plan that’s available to you. Another exception is based on showing that a “hardship” prevented you from becoming insured. People who believe they are exempt from the individual mandate can apply for an exemption through the federal government and ask not to pay a fine. You would make this request through the Health Insurance Marketplace.

Metal tiers

See page 11 for more information.

Out-of-network

Doctors, hospitals or other health care providers who are considered nonparticipants in an insurance plan. Expenses incurred by services provided by out-of-network health professionals may not be covered by the insurance plan or may have higher out-of-pocket costs.

Out-of-pocket costs

See page 12 for more information.

Out-of-pocket limit

See page 12 for more information.

Primary care physician

An affiliated doctor who has agreed to coordinate the medical care of HMO members. A PCP may practice in the area of family medicine, general medicine, internal medicine or pediatrics.

PPO

See page 10 for more information.

Premium

The amount that must be paid for your health insurance, required on a monthly basis.

Prescription drugs quantity limits

Certain drugs have quantity limits. Quantity limit is the maximum quantity that can be dispensed per each fill of medication or the maximum number of fills allowed for treatment of certain conditions. Specialty drugs, injectable drugs (except insulin) and select oral drugs (e.g., opioid analgesics) are limited to a maximum 30-day supply per fill.

Qualified health plan

Qualified health plans are ACA-compliant plans that cover essential health benefits and follow established limits on cost sharing. All QHPs, whether they are purchased through the Health Insurance Marketplace or directly from an insurance company, are grouped in different metal levels – Platinum, Gold, Silver and Bronze – based on actuarial value, or the percentage of health care costs the plan covers.

Qualified high-deductible health plan

High-deductible health plans typically feature lower premiums and higher deductibles than traditional insurance plans. If you have a qualified HDHP, you can use a health savings account to pay for qualified out-of-pocket medical expenses.

Special enrollment period

See page 20 for more information.
Contact us

Prospective member support:
Personal Alliance Sales Team at
(888) 909-4707 (TTY: 711)

Payment issues and questions:
Accounts Receivable at (888) 735-2542
Privacy pledge

HAP is committed to ensuring the privacy and security of your personal information. We define that as any information that can be used to identify you and relates to your past, present or future physical or mental health condition. It also includes any payment you’ve made or received for health care.

Your information is only available to HAP employees, on a need-to-know basis, and only when necessary to facilitate your care. We have guidelines and safety measures in place to protect your information and make sure you are safe. To review HAP’s privacy policy, visit hap.org/privacy or contact Customer Service to request a paper copy.

Health Plans for Everyone
Individual • Group • Medicare • Medicaid
hap.org

Subsidiaries
Alliance Health and Life Insurance Company  |  ASR Health Benefits  |  HAP Midwest Health Plan  |  HAP Preferred Inc.

HAP does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

HAP Personal Alliance HMO is offered through Health Alliance Plan (HAP), a state-certified Health Maintenance Organization. HAP Personal Alliance PPO is offered through Alliance Health and Life Insurance Company (Alliance), a wholly owned subsidiary of Health Alliance Plan (HAP).

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