hap | Personal Alliance®

Health Plans for Individuals and Families

2016

Welcome to the plan where you belong.

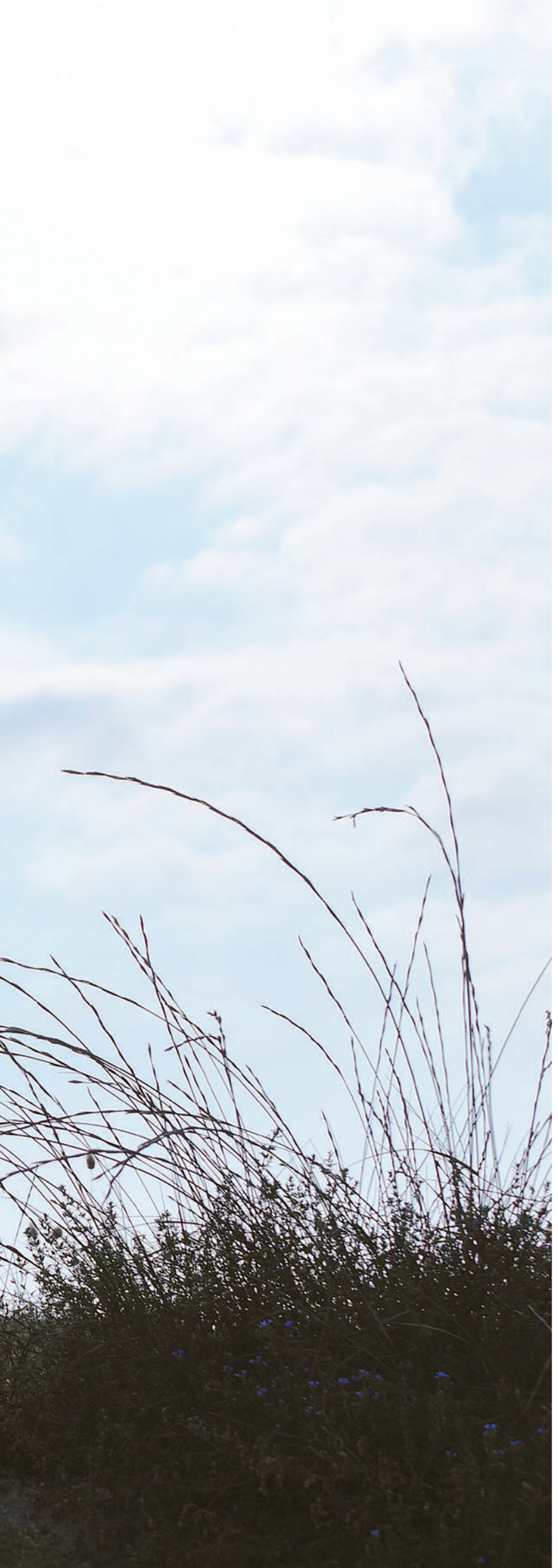
hap.org

IN YOUR COMMUNITY FOR OVER 50 YEARS

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 award-winning customer service – and, of course, excellent coverage from a large network of top specialists.

HAP has a plan for every age, stage and budget. So whether you're considering HAP Personal Alliance® for the first time or you are a current member looking to change plans, HAP has something for you.

Welcome to peace. Welcome to HAP.



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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 HAP Personal Alliance representative at **(855) WITH-HAP (948-4427)** or **TTY: 711**. You can also visit **hap.org/plans.**

Why Choose HAP?

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 and extend what your coverage can do.

Dedicated Personal Service to Get You Started

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 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** – There are HAP-affiliated urgent care centers throughout Southeast Michigan. These centers are equipped to handle issues that are not 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**. HAP plans also cover urgent care services anywhere in the world, giving peace of mind to members who regularly travel
- **Students Away at School Program** – Children (ages 5-26) who go to school outside our service area are covered for emergencies and urgent care without the need for authorization. Follow-up care is also covered (with limitations)
- **Global Emergency Services** – Be worry-free knowing HAP provides Assist America® and its global emergency services when you are 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, supply document translation services and more

  All services must be provided and arranged by Assist America. The company pays for all the assistance services it provides without limits on the covered cost, and its call center is fully staffed 24/7
- **Identify Theft Protection** – 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

HAP Extras – Going 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, qualified members can join Weight Watchers for a discounted rate, and HAP will pay the rest of the enrollment fee
- **iStrive® for better health** – This online health assessment tool lets you create a customized plan and gives you strategies designed by health care professionals to help you make healthy choices, overcome pitfalls and achieve your goals. Members can log in at **hap.org** and go to iStrive for more information

We're focused on your total health and well-being. So in addition to health plans, we provide you with a comprehensive offering of health and wellness options.

HAP Advantage Discount Program

You'll receive money-saving discounts and have access to a variety of health- and wellness-related activities, entertainment and websites, many of which are located throughout Southeast Michigan. For a complete list, visit **hap.org/discounts**.

- **YogaMedics** – receive two weeks of YogaMedics free, plus a 30-day offer for $69 at West Bloomfield and Farmington Hills locations
- **Palace Sports and Entertainment** – discounted tickets to events at The Palace, DTE Energy Music Theatre and Meadow Brook
- **Cranbrook Art Museum** – special two-for-one general admission pricing (of equal or lesser value)

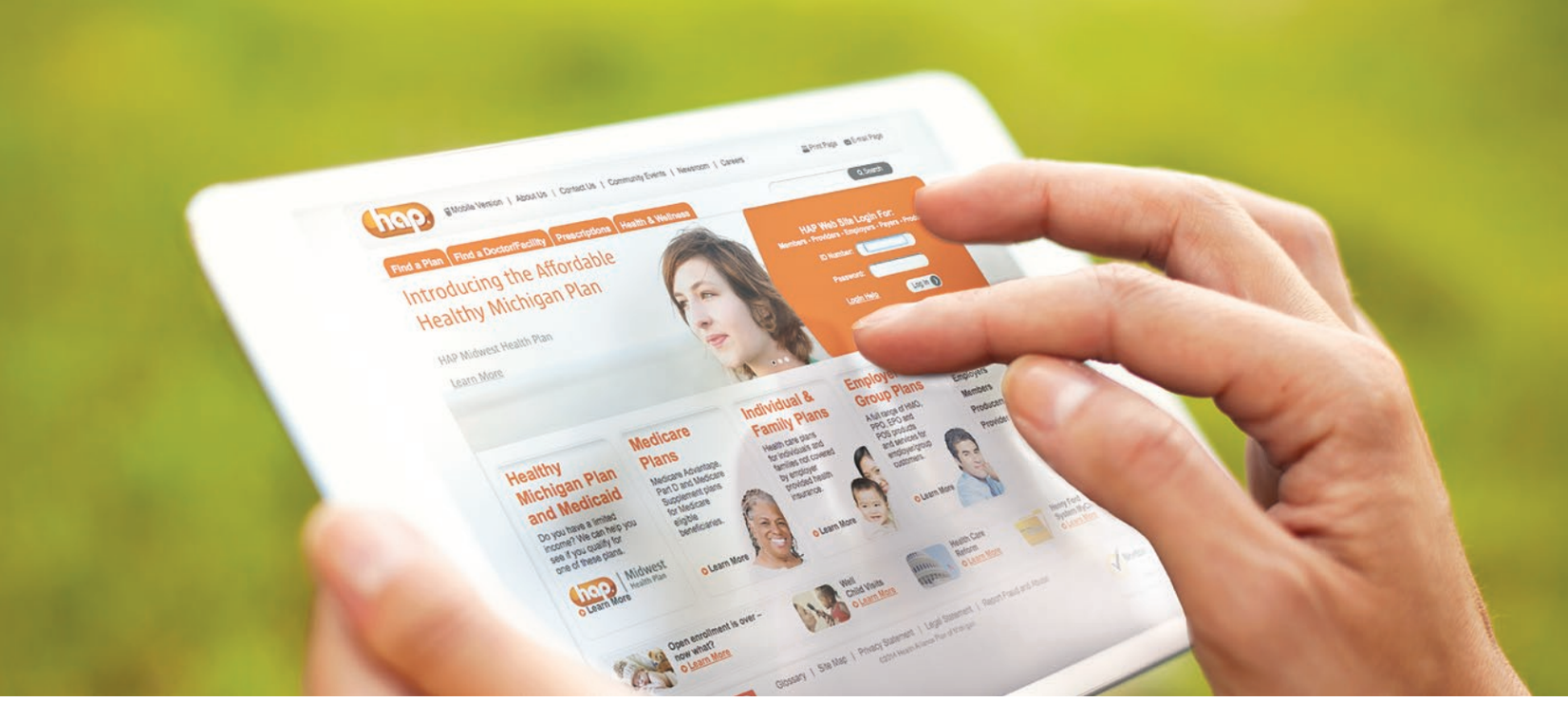
HAP CareTrack® Disease Management Program

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.

Some of the conditions this program can help manage are:

- Asthma
- Diabetes
- High blood pressure
- High cholesterol

* The HAP Advantage 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.



Online Tools via the HAP Member Portal

Members can manage details of their health plan at **hap.org**. Once registered, you'll have access to:

- **Health and wellness tools** – get reminders for upcoming screenings, health risk assessments and iStrive online digital coaching programs
- **Self-service tools** – choose a primary care physician, view claims and replace a missing ID card
- **Online Bill Pay** – pay your premiums online and have access to your account 24/7
- **Personal benefit and coverage information** – review what services are covered
- **Health reminders** – an online tool to remind you when important preventive services are available
- **Health library** – get reliable information on thousands of health topics, treatments, tests and interactive decision aids to help make informed decisions
- **Find a doctor/facility** – a search tool to locate a doctor or a facility either by name, by proximity to their home or business, or by specialty
- **Prescriptions** – a searchable list of prescriptions covered by your plan and associated costs and copay tiers

Mobile Apps

- **HAP OnTheGo** – makes it easy to find a doctor or nearby health care facility, download an ID card, check symptoms and manage health conditions
- **Assist America** – gives members immediate access to travel and legal assistance services. Assist America offers Identity Theft Protection free for HAP Personal Alliance members, which provides professional fraud support 24/7
- **HAP's Pharmacy Benefit** – enables you to manage your prescriptions anywhere. This mobile app lets HAP members price medications, view medication history, locate a pharmacy and research drug information. HAP members can also access this tool via the web by logging in at **hap.org/prescriptions**

Cost Carryover

Once you become a member, your health care costs from a previous plan will carry over to a new HAP Personal Alliance 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 Personal Alliance lets you carry over out-of-pocket costs to a new health plan.
The out-of-pocket limit 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 Personal Alliance, 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 Personal Alliance PPO health plan had the following:

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

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 health plan. Also, $2,000 of the $2,330 went toward the deductible of his new health plan.

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

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

Affordable Care Act

The Affordable Care Act was designed to improve access to health care for everyone. While more changes are coming over the next few years, most of the major provisions of the ACA became effective in early 2014. These changes were aimed at making health coverage more accessible and affordable for many more people. They include the creation of the Health Insurance Marketplace, coverage of Essential Health Benefits (EHBs) and individual tax credits.

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 individual or employer health plan, Medicare, or Medicaid, you will have to get it on your own or face a tax penalty. There are other types of coverage that will also satisfy this mandate. These include the Children's Health Insurance Program (CHIP), Veterans Affairs, the Indian Health Service or TRICARE.

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 (SEP).

Open Enrollment Period

The open enrollment period for health plans effective in 2016 will begin on November 1, 2015, and end on January 31, 2016. Whether you are considering HAP Personal Alliance for the first time or you are a current HAP member looking to change plans, HAP has a plan for you. To enroll in a HAP Personal Alliance health plan, talk with your agent, call **(855) WITH-HAP (948-4427)** or visit **hap.org/plans**.

The 2016 open enrollment period is November 1, 2015 through January 31, 2016.

Certain life events may qualify you to enroll outside of that time frame, which is called a special enrollment period.

Special Enrollment Period

You may be eligible to purchase a Qualified Health Plan (QHP) during or outside of the open enrollment period. An SEP can be approved for certain qualifying life events that allow you to change an existing QHP or sign up for a new health plan within 60 days of the event. Documented proof of the event must be included with the application. Qualifying life events include, but are not limited to:

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

To submit an application for an SEP, talk to your agent or call a HAP Personal Alliance representative at **(855) WITH-HAP (948-4427)** or visit **hap.org/plans**.

If you are currently enrolled in Medicare, you are 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.

Checklist for Enrollment

Here are some things you can do now to get ready for enrollment:

1. Visit **hap.org/plans** and review your health plan options or determine if your current health plan still meets your needs.
2. Educate yourself on how coverage works (insurance premiums, deductibles, copayments, 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 and expenses
   - Personal information on each person to be covered (date of birth, Social Security number, etc.).
5. Set a budget – how much you can afford to spend every month on health insurance, 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 are enrolling in an HMO plan, you will need to select a primary care physician (PCP) 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 included 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 are enrolling due to a special enrollment period.

Understanding the Costs of Your Plan

Every health plan is unique, and your specific benefits and costs may differ depending on the plan you choose. Cost sharing is the amount you pay for covered services, medications and medical supplies.

Understanding Deductibles and Out-of-Pocket Limits

A deductible is the amount you owe for certain covered services before your health plan begins to pay for them. HAP Personal Alliance plans have individual, or self-only, deductibles as well as family deductibles.

Family deductibles work differently depending on the type of plan you have. Most 2016 HAP Personal Alliance plans have **embedded** deductibles. The 2016 qualified high-deductible health plans that can be paired with a Health Savings Account (HSA) have **aggregate with a cap** family deductibles.

An out-of-pocket limit (OOPL) is the most you will pay for the combined total of all copays, coinsurance and deductibles for covered services in a benefit period (usually a calendar year). HAP Personal Alliance plans have an individual, or self-only, OOPL and a family OOPL. All 2016 Personal Alliance plans have an **embedded** family OOPL.

- **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. Copays do not 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 per-person 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 (within 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, noncovered prescriptions, or noncovered medical services and devices do not count toward it

These examples show how deductibles and OOPLs work in the different types of Personal Alliance plans we offer:

Types of Personal Alliance Plans

The information below describes the different costs associated with a non-HSA plan. HSA plans are treated a little differently. If you'd like to understand the differences, call your agent or a HAP Personal Alliance representative.

Type of family deductible: **Embedded**

Type of family OOPL: **Embedded**

An embedded deductible means each family member has a separate deductible.

Example:

Ben has a plan that covers himself, his spouse and his two children. His plan has a $2,500 individual/$5,000 family deductible and a $6,850 individual/$13,700 family OOPL.

Once Ben or one of his family members meets his/her $2,500 individual deductible, he/she pays only copays and/or coinsurance for covered services and HAP pays the rest.

Once the family collectively meets the $5,000 family deductible, everyone in the family pays only copays and/or coinsurance for covered services, and HAP pays the rest.

The embedded OOPL works much the same way. Once Ben or one of his family members has paid $6,850 in out-of-pocket costs, HAP pays the entire allowed amount of his covered services for the rest of the benefit period even though the family OOPL has not been met.

This continues until everyone's costs collectively reach the family OOPL of $13,700. Then, HAP pays all of the allowed costs for covered services for everyone covered under Ben's plan for the rest of the benefit period.

The most any one person in Ben's family will pay out of pocket for copays, coinsurance and deductibles is $6,850 per benefit period.

Qualified High-Deductible Health Plans That Can Be Paired with a Health Savings Account

Type of family deductible: **Aggregate with a cap**

Type of family OOPL: **Embedded**

An aggregate family deductible with a cap means all family members work together to meet the family deductible; however, the most any one person in the family will pay toward the family deductible is the self-only OOPL.

Example:

Ben has a qualified high-deductible health plan paired with an HSA that covers himself, his spouse and his two children. His plan has a $10,000 family deductible and a $6,450 self-only/$12,900 family OOPL.

Once Ben or one of his family members has paid $6,450 toward the family deductible, HAP pays the entire allowed amount of his/her covered services for the rest of the benefit period.

Once Ben's family collectively meets the $10,000 family deductible, all family members are considered to have met the deductible.

Once the family deductible is met, the family members pay only copays and/or coinsurance for covered services, and HAP pays the rest.

This continues until everyone's costs collectively reach the family OOPL of $12,900. Then, HAP pays all of the allowed costs for everyone covered under Ben's plan for the rest of the benefit period.

The most any one person in Ben's family will pay out of pocket for copays, coinsurance and deductibles is $6,450 per benefit period.

Health Savings Account

To maximize benefits, we offer PPO and HMO health plans that can be paired with a Health Savings Account (HSA). An HSA is an individually owned bank account for medical expenses. You can use your HSA to pay for your health care costs, from doctor and hospital visits to copayments, eyeglasses and prescriptions. Covered health care costs paid from your HSA can be applied toward meeting your annual health plan deductible. Any unused funds in your HSA will roll over annually.

HSA Benefits

Triple Tax Savings

1. Contributions are made with pretax dollars
2. The interest you earn on your HSA balance is not 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. After enrolling and upon approval, BenefitWallet will send a welcome kit to each member within 7-10 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.

Buying Coverage

There are several ways to buy a health plan – through insurance companies like HAP or through an agent.

Through HAP

You can purchase a Personal Alliance health plan for individuals and families through HAP or through the Health Insurance Marketplace. HAP is here to help you through the enrollment process whether you purchase directly from HAP or the Marketplace. You can rest assured that all HAP health plans will have the same high standards for coverage, quality and customer service.

Get Informed at hap.org/plans

This robust website reinvents the entire health plan shopping experience, from estimating to enrolling. It's filled with information and tools to help you determine which health plan is best for you.

- Get help choosing a plan
- Estimate plan costs
- Find out if you qualify for premium subsidy

Or speak directly with a knowledgeable, certified HAP Personal Alliance representative by calling us at **(855) WITH-HAP (948-4427).**

Essential Health Benefits

Essential Health Benefits (EHBs) are categories of health care services that must be covered by all QHPs. EHBs must include items and services within at least the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder 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

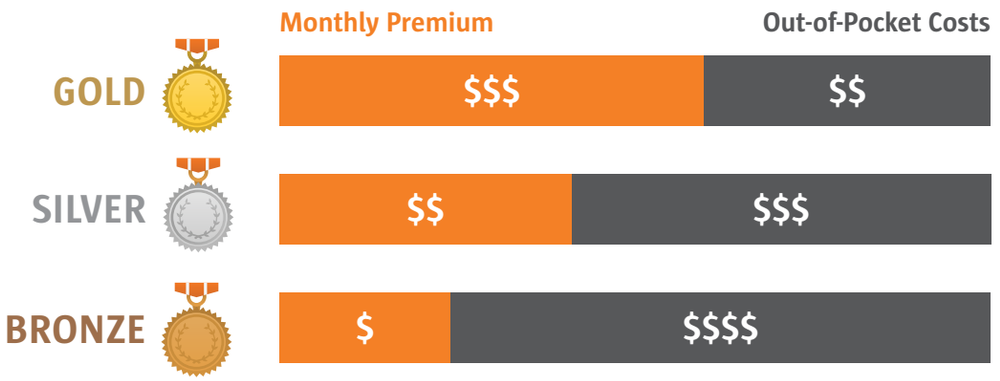
Health Plan Levels/Metal Tiers

Health plans are grouped into different metal tiers. HAP offers plans in the **Gold, Silver and Bronze tiers**. The idea behind "metal level plans," or metal tiers, is to allow you to compare health plans with similar coverage value.

What this means is that QHPs will be grouped in different metal levels based on the percentage of health care costs the plan covers. Another type of plan is a catastrophic plan, which offers 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.

Bronze health plans usually will have the lowest premiums and highest out-of-pocket costs – copays, deductibles and coinsurance – while Gold health plans usually have higher premiums and lower out-of-pocket costs.

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



Care Management

HAP continually strives to ensure that you receive all necessary services at the appropriate time and in the appropriate setting. We know that understanding the terms of your care can be confusing, to say the least. But there are two common terms you may encounter, and if you do, it helps to know what they mean.

- **HAP Restore Case Management Program** – HAP Restore is a free program that helps members like you get the personal support you need. 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
- **Utilization Management** – The processes we have in place to ensure that you get the right services and support at the right time, in the right amount and for as long as you need them. 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 do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Furthermore, HAP does not offer financial incentives to encourage inappropriate underutilization of covered services.

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

Our Customer Service specialists are available Monday through Friday from 8 a.m. to 5 p.m. and on Saturday from 8 a.m. to noon. During the Open Enrollment period, Customer Service hours are extended to serve you better. If you are deaf, hard of hearing or speech impaired, please call 711. If it is after business hours, please leave a message and we will return your call the next business day.

Our Family of Health Plans

HAP has an extensive network of leading doctors and hospitals and offers a variety of health plans to fit your particular budget.

HAP Choice Networks

Our Choice HMO networks offer you lower monthly premiums – by focusing your provider choices on doctors, specialists and hospitals that are closer to your home. These networks also control costs by improving collaboration and coordination between your doctors. Both of our Choice HMO network options let you choose from thousands of doctors, offer great HAP benefits and provide a primary care physician (PCP) to coordinate all of your care. But by narrowing the network size, you can save as much as 15 percent per year on premiums (savings vary by plan structure).

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.

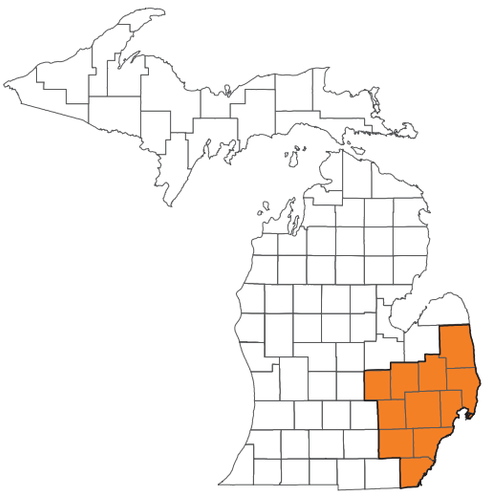
Genesys Choice Network

The Genesys Choice network includes more than 4,000 doctors affiliated with the Genesys Physician Hospital Organization (PHO). It includes Genesee County.

HMO

A Health Maintenance Organization (HMO) is a health plan that requires you to have a PCP within the network. This is your go-to doctor and first-line partner for better health. Your PCP is the doctor who will best know your medical history and will refer you to the right specialists if ever a need arises. HAP Personal Alliance offers several HMO health plans, with varying deductibles to fit every budget.

Once you enroll in an HMO plan, you will need to select a PCP. To locate a doctor, visit **hap.org/doctors**, or you can call the PCP hotline at **(888) 742-2727**. You can change your PCP anytime, and each person on your contract can select his or her own PCP. There are no restrictions on the number of times you can change your PCP.



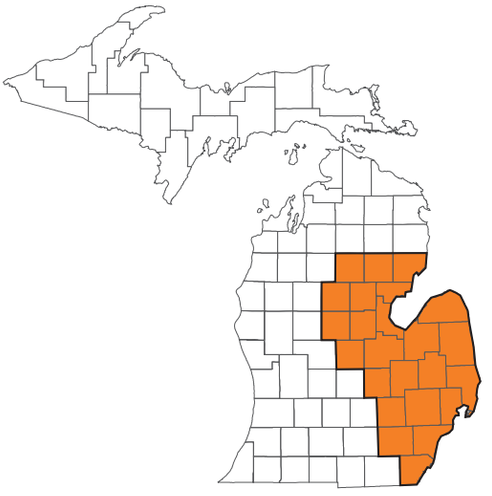
HMO Service Area Network

HMO Service Area Network

With our HMO health plans, you can receive services from doctors and medical facilities in the following 11 counties: Genesee, Lapeer, Livingston, Macomb, Monroe, Oakland, Sanilac, Shiawassee, St. Clair, Washtenaw and Wayne.

PPO

A Preferred Provider Organization (PPO) lets members seek care from providers either within or outside of the network, without referrals. The health plan offers a wide range of benefit options that includes incentives to seek care from network providers. HAP Personal Alliance offers several PPO health plans, with varying deductibles to fit any budget.



PPO Service Area Network

PPO Service Area Network

You can purchase Personal Alliance PPO health plans if you live in any of the following 24 counties: Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Iosco, Isabella, Lapeer, Livingston, Macomb, Midland, 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.

Members must reside within the service area of the plan in which they enroll to maintain active coverage in that plan.

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:** This means that you will 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**

View and learn more about HAP's Drug Formulary by clicking on the *Qualified Health Plan formulary* at hap.org/prescriptions

Tier 1 Drugs (Generic)

These are drugs that are approved by the Food and Drug Administration (FDA). They have the same active ingredient(s) 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.

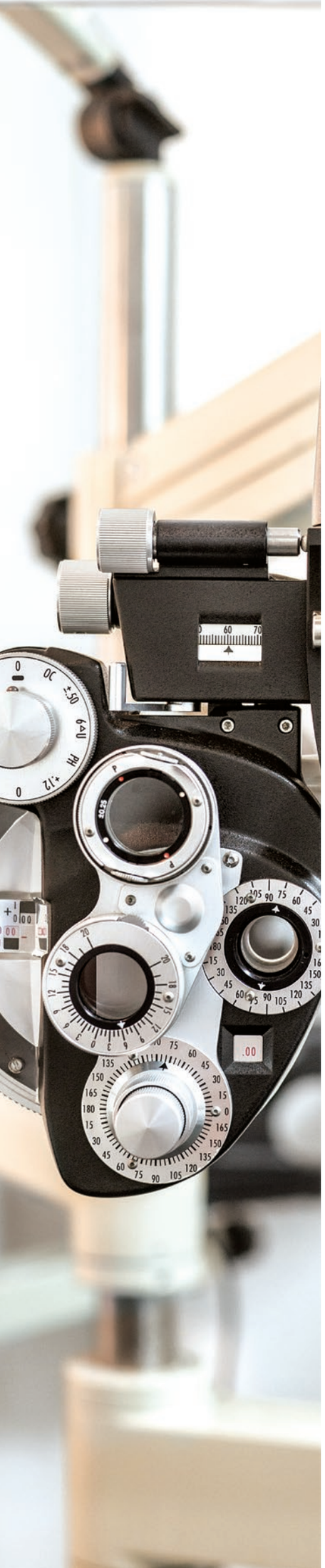
Tier 3 Drugs (Non-Preferred Brand Drugs)*

These are brand drugs that are approved by the FDA. They are 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 are 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 separate drug deductible that must be met for Tier 3 and Tier 4 drugs. Please refer to the Schedule of Benefits & Coverage charts located at the back of the brochure.



Medical Drug 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 details about your medical drug coinsurance.

Mail-Order 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 are required to fill your Specialty medications through Pharmacy Advantage.

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 under. All HAP Personal Alliance 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 oversize; 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

Delta Dental

When you're considering a health plan, don't forget about your smile. Dental care is so very 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.

Dental Benefits

One of the 10 Essential Health Benefits is pediatric dental, for those members 18 and younger.

If you purchase a HAP Personal Alliance health plan and have not or do not 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

A quality dental plan from Delta Dental can help make sure you get the care you need to stay healthy. Once you become a member, you can find additional benefit and coverage information and search for an affiliated dentist at **deltadentalmi.com**.

Payment and Self-Service Options

HAP makes it convenient to purchase and pay for your Personal Alliance Plan, as well as make changes to your payment options, through our Bill Pay tool.

Payment Options

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

- Electronic Funds Transfer (EFT)
- 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)

Credit, debit or EFT
If you choose 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 for you to 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.**

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 do not 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 26 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 an SEP, 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.

If your account does not have sufficient funds available to pay for your coverage, contact HAP Customer Service at **(888) 735-2542** to correct the situation. HAP is not 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.

Bill Pay

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 online Bill Pay tool. 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 ("Auto Pay")
- Make a one-time payment ("Pay Bill")
- Request a paper invoice to be mailed to you
- View your online payment history

To Access Bill Pay:

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 before your due date. We will continue to use the payment method you set up to pay your premiums.

Taxes Under the Affordable Care Act

On January 1, 2014, major provisions of the Affordable Care Act took effect to expand health coverage for the uninsured. New taxes and fees that were included in the law are embedded as part of the premium in the purchase of a Qualified Health Plan.

Cancellation of Coverage

Cancellation Process for Health Plans Purchased Directly from HAP

To request cancellation of the entire contract, the subscriber 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 **yourhap@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.

Cancellation Process for Health Plans Purchased through the Health Insurance Marketplace

To cancel your plan, please work directly with the Health Insurance Marketplace at **www.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 will not have access to medical or prescription benefits as of the first day of delinquency.

- You will 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 will 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 is not received prior to the due date, and you purchased a health plan through the Health Insurance Marketplace and received a cost savings, you will not 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 will 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 will 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

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 is designed for convenient reference only. Consult your policy/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 are not expressly listed as covered services in the policy/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 do not claim those benefits
- Cosmetic services, including, but not limited to, cosmetic surgery or any of the related services, such as presurgical/postsurgical care, 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 has not been prior authorized according to our benefit, referral and practice policies
- Dietary drugs, food and food supplements, except supplemental feedings administered via tube or intravenously
- Services provided if you are in police custody, unless an emergency exists or such benefits and services are provided at an affiliated hospital by an affiliated provider
- 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
- Gender reassignment services
- Services and supplies not medically necessary, as defined in the policy/contact
- Charges incurred outside of the United States for elective care, testing, procedures, or any services other than urgent care or care for an emergency medical condition

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 supply is purchased, before the procedure is performed or before the 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 do not 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 do not require precertification. However, we encourage you to notify us at least 60 days before your due date so we are better prepared to assist you at that time
- Outpatient services
- Durable medical equipment (DME) 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 (PET) scans
  b) Magnetic resonance imaging (MRI)
  c) Computed tomography (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

Glossary

Affordable Care Act (ACA)

The federal health care reform law enacted in March 2010.

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. Starting in 2014, individuals who are offered employer-sponsored coverage that's affordable and provides minimum value won't be eligible for a premium tax credit.

Calendar Year

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

Catastrophic Health Plan

Some insurers describe this as a health plan that only covers certain types of expensive care, such as hospitalization. Other insurers describe it as a health plan that has a high deductible and begins to pay only after you've first paid up to a certain amount for covered 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. To qualify off-Marketplace, you must be younger than 30 years old.

Coinsurance

The percentage of charges for certain covered services that you pay after your deductible has been met. Coinsurance percentages can vary by health plan. For example, if the health coverage or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount. Some plans don't have coinsurance at all.

Copay

A set amount (for example, $15) you pay for covered health care services, medications or other medical supplies. The amount can vary by the type of covered health care service. Copays do not count toward the deductible but do count toward the out-of-pocket limit. You will continue to pay copays after you have met your deductible, until you reach your out-of-pocket limit.

Cost Savings (also see Subsidy/Advanced Premium Tax Credit)

The amount of the monthly premium the government pays to help the taxpayer purchase health insurance. 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.

Cost Sharing (also see Out-of-Pocket Limit)

The "out-of-pocket" costs that you have to pay for health care services (your "share" of the costs). This term generally includes deductibles, coinsurance, copays or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers or the cost of noncovered services.

Deductible

The amount you owe for certain covered medical services before your health plan begins to pay for them. For example, if your deductible is $1,000, your health plan won't pay anything until you've met your $1,000 deductible for covered health care services that are subject to the deductible. There are per-person (individual) deductible amounts and family deductible amounts. The deductible may not apply to all services.

Essential Health Benefits (EHBs)

A set of health care service categories that must be covered by certain health plans. EHBs must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care;

mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including pediatric oral and vision care.

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

An online resource, the Marketplace is where individuals, families and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that assist people with low-to-moderate income and resources in paying for coverage. In some states, the Marketplace is run by the state. In others, it is run by the federal government.

Health Insurance Premium Tax

An excise tax assessed on all fully insured health plans, effective January 1, 2014, to help fund the ACA.

Health Maintenance Organization (HMO)

A form of health coverage that emphasizes preventive care. With an HMO, it generally includes inpatient and outpatient care. For the member, it means reduced out-of-pocket costs and no paperwork. An HMO requires you to have a primary care physician (PCP) within the network.

Health Savings Account (HSA)

An individually owned bank account for medical expenses for those enrolled in a high-deductible health plan. You can use an HSA to pay for health care costs, from doctor and hospital visits to copayments, 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 an HSA will roll over annually. The funds contributed to the account aren't subject to federal income tax at the time of deposit.

Individual Mandate

This includes health insurance coverage for individuals and families purchasing coverage on their own. The individual mandates have introduced new plan options that must include defined benefit offerings such as the 10 Essential Health Benefits. The Health Insurance Marketplace allows an individual or family to compare health plans based on price, benefits, quality and other important features. 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.

Medicaid

A state-administered health insurance program for low-income families and children, pregnant women, the elderly and people with disabilities. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies from state to state.

Metal Tiers

There are four categories of Marketplace insurance plans: Platinum, Gold, Silver and Bronze. Plans in these categories differ based on how you and the plan share the costs of your care. The categories have nothing to do with the amount or quality of care you get. HAP will not offer any Platinum plans in 2016.

Out-of-Network (OON)

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

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include copays, coinsurance and deductibles for covered services, plus all costs for services that aren't covered.

Out-of-Pocket Limit (OOPL)

The most you will pay for the combined total of all copays, coinsurance and deductibles for covered services during a benefit period (usually a calendar year). Once you meet your out-of-pocket limit, HAP pays all of the allowed amount for covered services. This out-of-pocket limit never includes your monthly premiums or noncovered services.

Primary Care Physician (PCP)

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

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) lets members seek care from providers either within or outside of the network, without referrals. The health plan offers a wide range of benefit options that includes incentives to seek care from preferred providers. HAP Personal Alliance offers several PPO health plans, with varying deductibles to fit any budget.

Premium

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

Qualified Health Plan (QHP)

Qualified Health Plans are Affordable Care Act-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 (HDHP)

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 costs.

Rx (Prescription)

A common abbreviation for a prescription written by a doctor for medication or equipment.

Special Enrollment Period (SEP)

If you qualify for a special enrollment period, you may apply for a new health plan or make changes to your existing plan within 60 days of the life event. Documented proof of the event must be included with your application or change form.

Subsidy/Advanced Premium Tax Credit (APTC)

The amount of the monthly premium the government pays to help the taxpayer purchase health insurance. 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.

Contact Us

Prospective member support:
Personal Alliance Sales Team at
(855) WITH-HAP (948-4427)

HAP member support:
PPO Customer Service at **(800) 944-9399**
HMO Customer Service at **(800) 759-3436**

Payment issues and/or questions:
Accounts Receivable at **(888) 735-2542**

For those deaf, hard of hearing or unable to speak:
Call 711

hap.org/individual