hap.org

Understanding Your Plan

2022 Member Annual Notifications

Free language assistance

HAP is committed to ensuring all our members and visitors can easily get the information they need. We can provide information through TTY and in various languages. We can also connect you with a qualified sign language interpreter at no cost.

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصي:711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܗ ܠܫܢܐ ܐܫܘܪܝܐ\ܐܬܘܪܝܐ، ܬܡܝ ܐܝܬܘܢ ܕܡܫܬܡܫܝܬܘܢ ܡܢ ܗܝܪܬܐ ܡܫܬܥܝܢܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ
ܩܠ ܡܢܝܢܐ (800) 422-4641 ܝܢ ܩܠ TTY: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

Contact us

If you have a question or complaint, our knowledgeable and friendly Customer Service specialists can help. Contact us by phone, letter, email or in person.

Call us:

Employer Self-funded Groups with ASO, EPO, HMO and PPO plans:
(866) 766-4709 (TTY: 711)
Monday through Friday, 8 a.m. to 7 p.m.

Employer Groups with HMO and POS plans:
(800) 422-4641 (TTY: 711)
Monday through Friday, 8 a.m. to 7 p.m.

Employer Groups with PPO and EPO plans:
(888) 999-4347 (TTY: 711)
Monday through Friday, 8 a.m. to 5 p.m.

Individual plans:
HMO: (800) 759-3436 (TTY: 711)
PPO: (800) 944-9399 (TTY: 711)
Monday through Friday, 8 a.m. to 7 p.m.

Federal Employees Health Benefit Program members:
(800) 556-9765 (TTY: 711)
Monday through Friday, 8 a.m. to 7 p.m.

Automated services line (all plans):
You can request an ID card or provider directory, change or select your primary care physician or confirm your coverage. Call the Customer Service number on your member ID card and follow the prompts.
24 hours, seven days a week

Helpful links:

- Member Annual Notifications
  hap.org/welcome
- Population health management
  hap.org/population-health
- Care management
  hap.org/care-management
- Subscriber information
  hap.org/hap-member
- Our rights and responsibilities statement
  hap.org/rights-and-responsibilities
- Quality management program
  hap.org/quality-management
- How pharmacy benefits work
  hap.org/prescription-drug

Write to us:

Group HMO and POS plans:
HAP
Attention: Customer Service
2850 W. Grand Blvd.
Detroit, MI 48202

Individual PPO, EPO and HMO plans:
Alliance Health and Life Insurance Company®
Attention: Customer Service
2850 W. Grand Blvd.
Detroit, MI 48202

Email us through hap.org:

Log in at **hap.org** and select *Send us a secure message*. Any message sent this way is safe and secure. We respond during normal business hours.

Visit us in person:

Detroit lobby
Monday through Friday, 9 a.m. to 5 p.m.
2850 W. Grand Blvd.
Detroit, MI 48202

Troy lobby
Monday through Friday, 9 a.m. to 5 p.m.
1414 E. Maple Rd. (Maple Rd. and Stephenson Hwy)
Troy, MI 48083

Flint lobby
Monday through Friday, 9 a.m. to 5 p.m.
2050 S. Linden Rd.
Flint, MI 48532

Table of Contents

About Your Health Plan

This booklet contains general information about your health plan. For specific details about your benefits, please refer to your plan documents. You can see them by logging in to **hap.org**. You may request plan documents in hard copy form by calling the Customer Service number on your ID card.

You may also request a hard copy of this booklet by calling the Customer Service number on your HAP ID card.

What's a health care network?

A health care network is a group of doctors, hospitals and other providers that HAP contracts with to provide you with care and services. Coverage for providers who aren't in your network varies depending on the type of plan you have.

Tiered networks (group plans only)

If your plan has a tiered network, you can get care and services from providers in any of your plan's tiers. Your costs for providers in the lowest tier may be lower than costs for providers in higher tiers. For more information, visit **hap.org/tiers**.

What type of plan do you have?

All HAP plans cover you worldwide for emergency and urgent care. But each plan type has different requirements for:

- Selecting a primary care physician
- Out-of-network coverage

Understanding these requirements is the first step in making informed health care choices.

What's a self-funded plan? (group plans only)

A self-funded plan is a plan that is funded from an employer group's general assets or trust. Alliance Health and Life Insurance Company administers the plan, along with HAP, which subcontracts with Alliance to provide certain services. Self-funded plans can be designed to work like a health maintenance organization, a point of service, a preferred provider organization or an exclusive provider organization. Please refer to your Benefit Guide for specific details about how your plan works.

What's a HMO?

HMO stands for health maintenance organization. In an HMO, all your care is arranged through a primary care physician you select. Depending on your plan type, you may be required to seek care within a specific network (such as the Henry Ford Choice Plan). Your PCP will provide your preventive and general care, keep track of your medical history and help you choose a specialist when you need one. Most HAP plans do not require you to get a referral to see a specialist that participate with HAP for an initial consultation. Some specialists or healthcare systems do require a referral even if HAP doesn't. HAP Primary Choice plans do require a PCP referral for specialty care, except from an affiliated obstetrician or gynecologist. For all HAP plans there are some services (like Botox injections or surgical procedures) that may require prior authorization to be covered.

What's POS? (group plans only)

POS stands for point of service. A POS plan operates like an HMO but also covers out-of-network care with higher out-of-pocket costs. You'll pick a primary care physician. You can refer yourself to some network specialists without a PCP referral, but some specialties do require a referral. In addition, some services may require a prior authorization to be covered.

What's a PPO?

PPO stands for preferred provider organization. You don't have to select a primary care physician with a PPO plan. However, a PCP can help you manage your health care so you get the best possible outcomes. When you belong to a PPO plan, you're covered for preventive services such as checkups and specialty care from an affiliated provider. You don't need a referral to see a specialist. If you decide to use a specialty provider who isn't in the HAP network, you may pay higher out-of-pocket costs. And, some services may require a prior authorization to be covered.

What's an EPO? (group plans only)

An exclusive provider organization plan, also known as an EPO, offers the freedom of our PPO but without the out-of-network benefits. With an EPO, you don't have to choose a primary care physician. And, you may see any doctor or specialist in HAP's EPO network without a referral. EPO members can also use our network of providers throughout Michigan. The statewide network includes HAP and Alliance Health and Life Insurance Company providers, as well as those in the ASR Physicians Care Network. Some services may require a prior authorization to be covered.

What's an EPA? (group plans only)

An EPA plan is designed to operate like an HMO. All of your care is arranged through a primary care physician whom you select. Your PCP will provide your preventive and general care, keep your medical history and help you choose a specialist when you need one. While you can refer yourself to some in-network specialists, you will need a referral from your PCP in order to get specialty care. You are covered worldwide for emergency and urgent care.

Your service areas

	Large Group		Small Group QHP		Individual/Family	
County	HAP HMO	HAP PPO	HAP HMO	HAP PPO	HAP HMO	HAP PPO
Arenac	X	X	X	X	X	X
Bay	X	X	X	X	X	X
Clare		X		X		X
Genesee	X	X	X	X	X	X
Gladwin		X		X		X
Gratiot		X		X		X
Hillsdale	X	X	X	X	X	X
Huron	X	X	X	X	X	X
Ingham		X				
Iosco	X	X	X	X	X	X
Isabella		X		X		X
Jackson	X	X	X	X	X	X
Kent		X	X		X	
Lapeer	X	X	X	X	X	X
Lenawee	X	X	X	X	X	X
Livingston	X	X	X	X	X	X
Macomb	X	X	X	X	X	X
Midland		X		X		X
Monroe	X	X	X	X	X	X
Muskegon		X	X		X	
Oakland	X	X	X	X	X	X
Oceana		X	X		X	
Ogemaw		X		X		X
Ottawa		X	X		X	
Roscommon		X		X		X
Saginaw	X	X	X	X	X	X
St. Clair	X	X	X	X	X	X
Sanilac	X	X	X	X	X	X
Shiawassee	X	X	X	X	X	X
Tuscola	X	X	X	X	X	X
Washtenaw	X	X	X	X	X	X
Wayne	X	X	X	X	X	X

- Most hospitals in the notated areas are affiliated with us.
- To see a list of providers, go to **hap.org** and click on Find a Doctor.
- HMO plan members aren't covered for care outside the plan's network, except for emergency and urgent care.
- EPA and EPO plan members are covered for care in their plan networks, but are covered worldwide for emergency and urgent care situations. (EPA members must select a PCP)
- PPO plans allow members to go out of their network for covered services.

What types of services are covered?

Your HAP plan covers preventive and medically necessary health care services and supplies if:

- They are included in your specific health plan.
- Some services and supplies may require doctor approval depending on your plan.
- They are required in an emergency or urgent care setting.

What types of services are not covered?

In general, your plan does not cover any service that is not medically necessary, such as:

- Cooking, bathing and other activities of daily living
- Long-term care
- Cosmetic surgery, such as breast enhancement (unless a mastectomy has been performed)
- Private rooms
- Liposuction
- Unproven experimental or investigational services

Your health plan documents contain a complete list of covered and noncovered services and any network restrictions. For a copy of these documents, log in at **hap.org** and click on *My Forms & Documents* or call the Customer Service number on your member ID card.

Prescription Benefits

You have prescription coverage if your plan has a prescription drug rider. Pharmacy benefits for individual plans may vary. Please refer to your health plan documents for details.

Covered drugs
Our list of covered drugs, also called a drug formulary, is available at **hap.org/prescriptions**. We also have a Drug Search tool for your use. Type in the drug name and the tool shows you if the drug is covered, the copay tier and the coverage rules. You can also view or print the list or call Customer Service to get a printed copy. The list is updated monthly because we continually review new medications and may add or remove drugs.

Prescription drugs
Prescription drugs are medications you get from a pharmacy and take yourself. We work with a team of health care professionals to establish the list of covered drugs. It contains all prescription medications we believe are needed for a quality treatment program. Your health plan will cover any listed drug if it's medically necessary, the prescription is filled at a plan network pharmacy and all other plan rules are followed. Log in to your **hap.org** account and click on *My Benefits* to see your prescription drug out-of-pocket costs.

Medical drugs
Medical drugs are generally supplied by your health care provider and given to you in your doctor's office or health care facility. Drugs for home infusion therapy are also considered medical. Our list of covered drugs includes select medical drugs. But, they're covered under your medical coverage rather than pharmacy coverage. Your plan documents explain your out-of-pocket costs for these drugs. Medical drugs that are also considered specialty must be obtained from HAP's specialty pharmacy.

Maintenance drugs
Maintenance drugs are medications prescribed for chronic, long-term conditions. These medications are taken on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are: high blood pressure, high cholesterol and diabetes.

The Maintenance Drug List contains well-established medications that are proven safe and effective. They're considered first-line therapy options for common chronic conditions. Most of these drugs are available as generic drugs. The list contains the most common dosage forms and strengths of a drug. Less common forms or strengths may not be covered as a maintenance drug.

You can get a 90-day supply of drugs listed on the HAP Maintenance Drug List if:

- It's filled at an eligible 90-day HAP retail pharmacy or through the Pharmacy Advantage home-delivery service
- Your physician writes the prescription for a 90-day supply

Refer to your plan documents for your copay information.

See the list and learn more about 90-day supplies of drugs at **hap.org/90dayfill**.

Drugs that are not covered

- Over-the-counter medications, unless specified on the list of covered drugs associated with your HAP plan
- Dietary food or food supplements
- Drug products used for cosmetic purposes
- Experimental drugs
- Drug products used in an experimental manner
- Replacement of lost or stolen medication
- Prescriptions filled at out-of-network pharmacies

Medication limits and requirements

Some covered drugs may have coverage limits or requirements. These are specified on the drug list and may include:

Prior authorization – You or your doctor must get approval from HAP before filling prescriptions for these drugs. Without prior approval, they may not be covered.

Step therapy – You may have to try one drug to treat your medical condition before we will cover another drug. For example: Drug A and drug B both treat your condition. We may not cover drug B unless you have tried drug A first and it did not work for you.

Quantity limits – The amount of a drug allowed or the number of times the prescription can be filled can vary. Limits are set depending on the drug and the condition. Specialty and injectable drugs (except insulin) and select oral drugs (such as opioid painkillers) are limited to a maximum of a 30-day supply per prescription. Some specialty drugs are limited to a 15-day supply the first time the prescription is filled.

Generic drugs – Generic drugs cost less than brand-name drugs. When a generic drug approved by the Food and Drug Administration is available, your prescription will be filled with that version. Generic drugs have the same active ingredients and are equal in strength and dosage to brand-name products.

Specialty drugs – Specialty drugs are medications that may require special handling, provider assistance and patient training for safe and effective use. They're available from Pharmacy Advantage, a specialty pharmacy service that delivers them to your home. Specialty drugs require prior authorization. They are limited to no more than a 30 day supply at one time. For more information, you or your doctor can contact Pharmacy Advantage at **(800) 456-2112**.

Requesting an exception

You may request an exception to formulary requirements or to receive coverage for a drug not included on our list. Your doctor must submit a prior authorization request explaining why it is necessary.

To request an exception for a drug that is not on our covered drug list or coverage for a drug that requires prior authorization, fill out the appropriate form at **hap.org/mrf**, and mail or fax it to us at:

Mail: HAP
Attention: Pharmacy Care Management
2850 W. Grand Blvd.
Detroit, MI 48202

Fax: **(313) 664-8045**

Please call Customer Service at the number on your ID card if you have questions or need help.

Where to fill your prescription

A HAP-affiliated pharmacy

To find a retail pharmacy near you, go to **hap.org** and click on *Find a Doctor*. Or call Customer Service.

Pharmacy Advantage home-delivery service

We are affiliated with Pharmacy Advantage home-delivery service. You can refill or renew your prescriptions for a 90-day supply safely and securely online through Pharmacy Advantage. Prescriptions are delivered in seven to 10 working days by first-class mail. When ordering, make sure to allow for enough mailing time to prevent running out of your medicine. For more details, visit **PharmacyAdvantageRx.com** or call **(800) 456-2112**.

If you have questions about your prescription benefits, please call the Customer Service number on your HAP ID card.

Prescriptions while traveling

If you need to fill a prescription when you're away from home, we have a national network of pharmacies that includes:

- Costco®
- CVS®
- Kroger®
- Meijer®
- Rite Aid
- Walgreens
- Walmart®

A full list is available at **hap.org/pharmacy**.

Care Away from Home

Travel assistance from Assist America*

Your plan covers urgent and emergency care worldwide. If you become ill or injured while traveling, you may need additional help. Our partner Assist America can provide it. If you're more than 100 miles away from home or outside the U.S. (for no more than 90 days in a row), you can call their 24/7 operations center for services such as:

- Locating a health care provider
- Hospital admission
- Ambulance transportation
- Return transportation to U.S. for treatment
- Replacing lost prescriptions, eyeglasses or luggage

For more information, visit **hap.org/travel.**

**Assist America is a value-added program. This means that the services and products made available under this program are not covered benefits or otherwise payable by your health plan. HAP and 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 this program.*

ID theft protection from Assist America

Assist America provides HAP members with 24/7 telephone support, step-by-step guidance from anti-fraud experts and expert case workers to help you:

- Cancel stolen cards and get new cards.
- Notify police, financial institutions and government agencies.
- Notify credit bureaus and file paperwork to correct your credit reports.

Connect online or on the Assist America mobile app

To use Assist America's travel or ID theft protection services, go to **assistamerica.com/HAP**. Or use the Assist America mobile app. It provides one-touch calling to the 24/7 Emergency Operations Center, pharmacy locator and more. Online or on the app, use the HAP member code **01-AA-HAP-07113**.

Students Away at School program

PPO plan

Students are covered for medical care across the country. HAP has partnered with Aetna Signature Administrators® to offer you the Aetna national PPO network outside of Michigan and Northwest Ohio*. Aetna's network gives you access to more than 1.4 million providers including over 6,100 hospitals and thousands of MinuteClinic® locations around the country. If they seek care, they:

- Are covered whether they're in or out of the HAP network area
- May pay more for services if they go to a doctor or facility outside of HAP's network

Students Away program with HMO, POS, EPA or EPO plans

What is covered?

If a student (age 17 to 25) attends school outside their network area, they are covered for services that include:

- Emergency or urgent care
- Nonemergency and minor illness or injury and related services that include:
  - Follow-up visits
  - Outpatient imaging and lab tests
  - Short-term physical therapy for rehabilitation
  - Durable medical equipment (if covered by your health plan)
- Routine allergy shots, flu shots and immunizations
- Some services for managing chronic conditions (for example, asthma or acne)
- Office visits to get a birth control prescription (the visit is covered, but not the birth control)
- Prescription drugs (according to your health plan)

Students Away at School covers services at the in-network level. You must get HAP's authorization to qualify for this program. See your plan documents for specific coverage details.

Emergency care

Covered students do not need authorization for urgent or emergency care. They're always covered for urgent or emergency care. This includes mental health services. In case of a serious illness or injury, they should go directly to the nearest emergency room or urgent care center or call **911**.

Hospitalization

For extended inpatient care, HAP reserves the right to transfer your student to a facility in the HAP service area.

Urgent care

Urgent care is covered for minor illness or injury such as a sprained ankle or flu. This includes X-rays and lab tests when done in an outpatient setting. Call Customer Service or visit **hap.org** to find out if there's an affiliated urgent care center nearby. If there isn't, the student should go to the nearest urgent care center. Some college health care centers also provide urgent care services.

Follow-up care

In some cases, your health plan must authorize follow-up care before the student gets treatment. We may also require a review by our medical director. Call Customer Service for more information.

What is not covered?

Depending on your plan type, these services may not be covered under Students Away at School:

- Routine complete physical examinations
- Gynecological exams
- Elective surgeries or hospitalizations
- Routine eye exams and eyeglasses (optometry and optical services)
- Routine OB-GYN services for pregnancy
- Physician visits or physical therapy, occupational therapy or other therapies or treatments that do not have a prior authorization from your health plan
- Vaccines given for the sole purpose of travel

The Students Away at School Program does not cover dependent members permanently living out of our service area, even if the dependent is a student. Your plan does not cover dependent children who live with a custodial parent outside of our service area.

Call Customer Service for questions about the Students Away at School program.

*Northwest Ohio: Defiance, Fulton, Henry, Lucas, Ottawa, Williams and Wood.

Member Extras

Digital wellness manager

iStrive® for Better Health is our digital wellness manager. It offers free tools and programs to help you reach your health and wellness goals. Powered by WebMD Health Services, it's personalized for each member. iStrive can help you assess your health, set and manage goals and make choices to improve your well-being. See **hap.org/istrive** for more information.

HAP Discounts

We offer a variety of health and wellness discounts. Go to **hap.org/mydiscounts** for more information.

Balanced Living

You can find information on topics such as fitness, nutrition, managing your health and understanding your health plan at our Balanced Living blog. Visit the blog at **hap.org/balancedlivingblog**.

Getting Care

Choosing a primary care physician

A primary care physician is a HAP doctor who is usually a general practitioner, internist, family practitioner or pediatrician. Even if your plan doesn't require you to choose a PCP, we believe it's an excellent idea to have a PCP as a "go-to" doctor. The relationship you have with your PCP is important because he or she knows your complete medical history and will make sure you get the care you need.

Depending on your plan type, you may be required to choose a PCP and receive care in that doctor's network.

HMO and POS plans:

Members of our HMO and POS plans must select a PCP. When you need specialty care, your PCP will refer you to a qualified specialist.

PPO and EPO plans:

PPO and EPO plan members don't need to choose a PCP. However, we recommend that you choose a primary doctor to keep your medical history and to help you get the care you need. Our Customer Service specialists can help you find a primary doctor or specialist based on your needs.

Choosing a doctor is an important decision, so we offer several ways to help:

- **Provider directory**: View the directory by logging in to **hap.org** and clicking on *Find a Doctor*. It contains doctor profiles, maps and driving directions. It also lets you compare up to three doctors in a side-by-side view that highlights education, residency, certification, gender, languages spoken and hospital admitting privileges. When you log in, the search is customized to your plan, and you can select your PCP with a simple click of a button.
- **PCP selection specialist**: HMO and POS plan members can call a PCP selection specialist at **(888) 742-2727**, Monday through Friday from 8 a.m. to 7 p.m.
- **Customer Service**: PPO and EPO plan members can call Customer Service for help selecting a doctor.

Changing PCPs

As an HMO or POS member, you may change your primary care physician any time, for any reason, unless you're hospitalized. You can change your PCP by calling **(888) PIC-A-PCP (1-888-742-2727)**. Or, you can call Customer Service atthe number on your ID card and use our automated services or speak to a Customer Service representative. You can alsoselect a PCP by logging in to **hap.org**, clicking on *Find a Doctor* and selecting a PCP.

If you change your PCP:

- The change is effective immediately.
- Depending on your plan type, you may have to choose a PCP and receive care in a specific provider network.

Transitioning your child to adult care

When your child turns 18, it's time to think about moving from a pediatrician to an adult provider. If you'd like help selecting a doctor for your young adult, contact Customer Service.

Visiting your doctor's office

After you select your primary care physician, schedule an appointment as soon as possible. This first visit is a chance for your doctor to learn about your family and personal medical history and any conditions you may have. This helps your doctor to treat you when you need care.

Get the most out of your doctor visits

- Prepare a list of topics, health concerns and questions.
- Talk openly about your overall health.
- Be sure to bring along a list of all medicines you take (including vitamins and supplements).
- Take notes if you need help remembering what your doctor tells you.

Make sure to ask about:

- Medical center and doctor office hours
- When to schedule other checkups, preventive tests and screenings
- How to schedule same-day or next-day appointments for urgent medical conditions
- How to obtain medical care or advice if the office is closed

For a helpful guide to print out and bring with you, visit **hap.org/doctorchecklist**.

Your role as a patient

You and your doctor are both committed to your health. Your doctor should respect your choices. And it's important that you show your doctor the same respect. Either you or your doctor may choose to end the doctor-patient relationship if it's not a good one. When you communicate and work together, getting proper medical care is much more pleasant.

A healthy relationship with your doctor depends on being able to:

- Respect your doctor's ability to provide medical care.
- Follow your doctor's instructions.
- Ask questions and discuss your concerns.

Canceling appointments

Your doctor may charge a fee for missed appointments or for those canceled less than 24 hours in advance. You're responsible for paying any charges resulting from missed appointments. Your health plan doesn't cover these charges. Ask your doctors about missed or canceled appointment policies.

Continuing treatment with an out-of-network provider

If you're in an active course of treatment with a doctor that is not in your network, we provide continuity of care. This means we'll work with you and your doctor to move your care to one of our doctors when it's safe to do so.

Here's how it works:

1. You can continue regular visits with your current doctor to track your condition and get treatment.
2. Your current doctor will prescribe your medicines and monitor your treatment plan.
3. One of our nurses will call you and your health care provider to discuss your diagnosis, history and current treatment plan. They'll review the information and coordinate care with your doctor.
4. We'll move you to an in-network provider when it's safe to do so.

If you need this service, call Customer Service to start the process. When you call, have this information handy for us to send to our medical team:

- Your name, address and telephone number
- Your ID number
- Your coverage effective date
- The name, address and telephone number of the doctor currently treating you

Preventive service guidelines

Available on our website are:

- A schedule of preventive services to help keep the whole family healthy:
    1. Log in to **hap.org**.
    2. Select *Member Resources*.
    3. Select *Preventive Services Reference Guide*.
- Updated information on health education classes available in your area

Where to go for care

Medical problems can vary in urgency. And, out-of-pocket treatment costs can vary depending on the type of treatment and health plan. So, it's important to know when to go to an emergency room, an urgent care center or your doctor.

Emergency room, urgent care or my PCP?

Knowing whether to go to an emergency room or an urgent care can save you time and money. ER visits usually cost more than visits to an urgent care clinic. If you can reach your primary care physician, they may help guide you on where to go for treatment. On the following pages are two charts that may also help.

If you're still not sure where to go based on your symptoms, go to the nearest ER or call **911** for help.

Emergency room

If you or a loved one experiences a severe or life-threatening medical condition, go to the nearest ER or call **911** for help.

Urgent care

For issues that are not life-threatening, such as a sprained ankle or a minor cut that may need stitches, an urgent care clinic may be better and less expensive. Urgent care clinics are staffed by doctors and are open after normal business hours. Finding one near you is easy. Keep a list of urgent care centers and their operating hours handy. Visit **hap.org/urgentcare** to find a full list.

Retail clinics

HAP members can get care at retail clinics such as CVS Minute Clinics or Henry Ford Walk-In Clinics. Their doctors, nurse practitioners and physician assistants can help with nonemergency conditions and prescriptions. No appointment is needed, and the cost is the same as a PCP office visit.

PCP

When it's not an emergency, you may want to try to see your primary care physician. Your PCP's office may set aside same-day or next-day appointments for urgent care needs. Call your doctor's office for its urgent care guidelines.

24/7 online doctor visits*

You might also consider talking to a doctor online. You can talk to a doctor anytime of the day or night wherever you are. HAP has partnered with American Well® (Amwell) to bring telehealth services to our members. Telehealth lets you visit licensed, board-certified doctors 24/7 on a secure site. They can help you with nonemergency medical issues and prescriptions. You can use this service online or by mobile app. Get easy, affordable access to doctors wherever and whenever you need them. Log in to **hap.org**, click on *My Care*, then click on *Telehealth (virtual doctor visit)* to get started.

**See your plan documents as virtual care provider access as a covered benefit may vary based on your coverage benefits.*

Where do I go if I have one of these symptoms?

	PCP	Telehealth	Urgent care	Emergency room
Back pain	✓	✓	✓	
Mild asthma	✓	✓	✓	
Minor headache	✓	✓	✓	
Sprain or strain	✓	✓	✓	
Nausea, vomiting or diarrhea	✓	✓	✓	
Bumps, cuts or scrapes	✓	✓	✓	
Cough or sore throat	✓	✓	✓	
Ear or sinus pain	✓	✓	✓	
Eye swelling, irritation, redness or pain	✓	✓	✓	
Minor allergic reaction	✓	✓	✓	
Minor fever or colds	✓	✓	✓	
Rash or minor bumps	✓	✓	✓	
Stitches			✓	
Minor burn			✓	
Sudden or unexplained loss of consciousness			✓	
Signs of heart attack, such as sudden or severe chest pain				✓
Signs of stroke, such as numbness of the face, arm or leg on one side of the body; difficulty talking; or sudden loss of vision				✓
Severe shortness of breath				✓
High fever with stiff neck, mental confusion or difficulty breathing				✓
Coughing up or vomiting blood				✓
Cut or wound that won't stop bleeding				✓
Poisoning				✓
Trauma to the head				✓
Suicidal feelings				✓
Partial or total amputation of a limb				✓

This is not a complete list of conditions. These are examples only. If you believe you're having an emergency, call 911 immediately or go to the nearest emergency room.

The information provided is intended to be general information and is provided for educational purposes only. It is not intended to take the place of examination, treatment or consultation with a doctor. HAP urges you to contact your doctor with any questions you may have about a medical condition.

Where do I go if I need this kind of service?

	Care needed	Where to go	Average wait time from call to visit	Things to remember
Well-visits and annual exams	Routine checkups scheduled at regular times, such as once a year	Go to your PCP or your doctor's office.	Within 30 days	Depending on your plan, you may be required to choose a doctor and get care within a certain network. See your plan documents for possible network restrictions.
Routine office visits	Nonurgent office visits with mild symptoms, like a sore throat	Go to your PCP or your doctor's office.	Within four days	Depending on your plan, you may be required to choose a doctor and get care within a certain network. See your plan documents for possible network restrictions.
After-hours care	Care needed outside of your PCP's or doctor's normal business hours	Call your doctor's office. They may have a recording that tells you where to seek care or how to get in touch with a nurse or doctor. For some conditions, you may choose an online visit with a telehealth doctor. Or go to an affiliated urgent care center.	Same or next day	Depending on your plan, you may be required to choose a doctor and get care within a certain network. See your plan documents for possible network restrictions.
Urgent care	Serious but non-emergency injury or illness, such as a sprained ankle or minor wound	Go to your PCP or your doctor's office or any affiliated urgent care center. For some conditions, you may choose an online visit with a telehealth doctor.	Same or next day	Go to **hap.org/urgentcare** or call Customer Service for a list of affiliated urgent care centers. You can use any affiliated urgent care center.
Emergency care	An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm	Go to the nearest emergency room immediately or call 911.	You can get emergency care right away, 24/7 at any emergency room worldwide.	If you're admitted to a hospital not affiliated with us after an emergency, you may be transferred to an affiliated hospital when you are stable. If you refuse the transfer, you may have to pay for your care.
Specialty care: HMO plans	Specialty care not provided by your PCP	Call your PCP first for a recommendation.		Talk to your PCP to schedule an appointment with a specialist. Your PCP can refer you to a doctor best suited for your needs. Depending on your plan, you may be required to get care in a certain network. HMO members do not have out-of-network coverage.
Specialty care: PPO, EPO and POS plans	Specialty care not provided by your primary doctor	Go to the specialist your doctor recommends or you choose.		We recommend calling your PCP or doctor before seeing a specialist, but it's not required. EPO members don't have out-of-plan coverage.

Mental health and substance abuse treatment

We offer help for mental health and substance abuse (alcohol and drug) disorders. The Coordinated Behavioral Health Management team can help with:

- Finding a behavioral health/substance abuse specialist (You can also choose a behavioral health/substance abuse specialist by logging in to **hap.org** and clicking on *Find a Doctor*
- Monitoring care during inpatient, partial hospital, and autism treatment
- Ensuring medication is right for you
- Finding support groups
- Education for specific diagnoses
- Managing your condition

Call (800) 444-5755 (TTY: 711) Monday-Friday from 8 a.m. to 5 p.m. For after hours and urgent weekend calls, please call to speak to a Master's level clinician. Calls that are not emergencies are returned within 24 hours or the next business day. You have the same confidentiality rights with our behavioral health team as you do with a doctor or nurse.

If you need emergency behavioral health care, go to the nearest emergency room or call 911.

You don't need an authorization for routine outpatient behavioral health care with a plan-affiliated provider. An authorization is required for autism treatment, neuropsychological and psychological testing. Your HAP contracted behavioral health provider may request authorization for services through HAP's Provider Portal 24/7, 7 days a week. HMO and EPO members must get all care from affiliated health care providers.

Emergency behavioral health/substance abuse hospital admissions do not require prior authorization. Providers can submit admission requests through HAP's provider portal 24/7, 7 days a weeks or by phone during normal business hours if the portal is not available.

Women's health services

Members can get OB-GYN services from any plan-affiliated doctor without a referral. Services can include:

- Pelvic exams and Pap tests
- Breast exams or mammograms
- All prenatal visits
- Standard lab tests
- Ultrasound
- Care for a health problem that requires several visits, such as appointments after surgery
- Deliveries
- Inpatient OB-GYN care

Your doctor may still have to get authorization for some OB-GYN services. Check your plan documents to see if you need to get OB-GYN services from a particular network.

Breast reconstruction

The Women's Health and Cancer Rights Act of 1998 grants certain mastectomy-related benefits. If you receive these benefits, coverage will be provided in consultation with your attending doctor.

We offer coverage for:

- Reconstruction of a breast removed by a mastectomy
- Surgery on and reconstruction of the other breast to provide a symmetrical look
- Prosthetics
- Treating problems arising from the mastectomy, including swelling of the surrounding tissue after surgery

Your plan's deductibles, coinsurance and copays may apply. Check your plan documents to view your out-of-pocket costs. If you would like more information on these benefits, please call Customer Service.

HAP Care Management

Chronic and complex conditions can require multiple health care providers, prescriptions, appointments and treatments. Our innovative care management program helps coordinate health services for all members, including those with multiple or complex needs. This program helps members understand their conditions and learn how to manage them.

This program is free to members and focuses on:

- Improving the member's health
- Reducing the risk of hospital readmission
- Avoiding unnecessary emergency room visits

Members talk on an ongoing basis with a nurse by phone. The nurse works with the member and their health care providers to:

- Determine which case management program will best meet their needs.
- Get access to education, services and local resources.
- Coordinate services that may include a behavioral health specialist to help identify emotional or behavioral triggers that affect the ability to follow the doctor's treatment plan.

For more information about HAP's Care Management programs or to enroll, call **(800) 288-2902 (TTY: 711)** or email **caremanagement@hap.org**. You can also refer yourself by going to **hap.org/caremanagement** and completing the contact form. Your doctor, family member or caregiver may also refer you to these programs.

Referrals and prior authorizations

Do I need a referral to see a specialist?

HMO members

HAP does not require referrals from a primary care physician to see a specialist. But a specialist may require a referral from a member's PCP. Many specialists are booked months in advance. They may only accept patients whose PCPs say they need specialty care.

PPO members

Members with a PPO plan don't need to worry about referrals. They have the flexibility to seek care from doctors in and out of the network. But they might pay more if they choose a doctor outside of our network.

Do I need to get prior authorization for treatment?

Prior authorization is an approval from your health plan. It's required before you can receive certain tests, treatments, medication or medical supplies. This is the process by which we review whether elective medical services are appropriate so you get the care you need.

To view a list of services, medications and supplies that require prior authorization, log in at **hap.org** and click on *My Benefits*, then select *Referrals & Prior Authorizations*. If you have questions about the prior authorization process or your benefits and coverage, please call Customer Service.

How do I get prior authorization?

You or your doctor can send a request to HAP for prior authorization for treatment.

That request is reviewed by the Utilization Management team. This team is made up of nurses and benefits specialists specially trained to make sure that you get the right care. They compare the request to an evidence-based, nationally recognized set of standards. This team can approve a request, but they can't deny one.

If the request doesn't meet the standards, it will be reviewed by a HAP medical director, who is a licensed doctor. Our medical director will decide to approve or deny the request. Only a HAP medical director can deny a request.

You and your doctor will both receive notice of approval or denial of the request, usually within 14 days. If your request is denied, the reason will be explained in the notice.

Your request must be approved before you receive services. Otherwise, coverage for these items may be denied or you may have to pay penalties.

Do I need prior authorization for hospital services?

All nonemergency admissions need prior authorization before you receive services. If you need inpatient care and treatment at a hospital, skilled nursing facility, hospice or behavioral health facility, your doctor or hospital should notify us by calling the number on your ID card.

If you're admitted to a hospital that isn't affiliated with us, we may call the doctor treating you to check your status and your care plan. When it's safe, you may be transferred to an affiliated hospital. If you refuse to be transferred, your care at the nonaffiliated hospital won't be covered. Or, it may be covered at a reduced benefit level.

How does HAP make decisions about prior authorization?

Utilization management is the method we use to review treatment plans to make sure you get appropriate care. This means getting the right care at the right time in the right place. Utilization management uses proven medical practices from doctors across the country as a framework for reviewing your doctor's requests. And we conduct different review processes before, during and after your care:

Medical screening: This regular screening process is done before services happen. It's used to determine whether the suggested care is right for your condition.

Retrospective care: This is a review of services after they're completed to assess medical necessity and theprovider's billing practices.

Our pledge to members

We continually strive to ensure that you get the right care at the right time and in the appropriate setting. All our decisions are based on whether care and service are appropriate and covered. We don't reward practitioners or review team members for issuing denials of coverage or service. And, our decisions are not based on incentives, we don't offer financial incentives to encourage underuse of covered services.

Questions

If you have questions about these review processes, please call the appropriate number below. If you're deaf, hard of hearing or unable to speak, dial **711** for TTY service. If needed, we can call on your behalf or connect you with other departments to get your questions answered. After business hours, please leave a message and we'll return your call the next business day. For language assistance, please call customer service.

	Call about:	Hours of operation
Admissions team	Admissions, transfers, inpatient review, skilled nursing facilities and rehabilitation services	Admissions Team, **(313) 663-8833 option #3 (TTY:711)** Monday through Friday 8 am to 5 pm. If after hours, follow prompts to the on call nurse. Inpatient Rehabilitation Services, **(313) 664-8800 (TTY: 711)** Providers can leave a message and a UM case manager will return call.
Referral team	Outpatient referrals and services such as durable medical equipment, home care, home infusion and end-of-life care	**(313) 664-8950 (TTY: 711)** Monday through Friday, 8 a.m. to 12 p.m. and 1 p.m. to 4 p.m.
Pharmacy	Pharmacy related review questions such as prior authorization and formulary exception	**(800) 422-4641 (TTY: 711)** Monday through Friday, 8 a.m. to 4:30 p.m.
Coordinated Behavioral Health Management (CBHM)	Admission and prior authorizations. Can be entered online 24/7 through HAP Provider Portal	Monday through Friday 8 a.m. to 5 p.m.: **(800) 444-5755 (TTY: 711).** For after hours and urgent weekend needs, call to speak to a Master's level clinician.

Planning for life and death decisions

If you become seriously ill or are badly injured in an accident, your family may face difficult life-and-death choices. To make sure they know and follow your wishes, you can write an advance directive. An advance directive is a legal document that can be used if you become unable to make decisions. It outlines your wishes regarding treatment or names another person to make decisions or both. You can change your representative at any time. The durable power of attorney for health care is a form of the advance directive.

If you're 18 or older, you should:

- Get a copy of Know Your Medical Rights by calling Customer Service or visiting **hap.org/rights**.
- Decide what kind of care you do or don't wish to receive in the future.
- Select a representative.
- Write an advance directive or durable power of attorney for health care (also called a health care power of attorney).
- Give a copy of your durable power of attorney for health care to your representative and your doctor.
- Discuss your wishes with your doctor and family.
- For more information about advance directives or to download a form, visit **henryford.com/AdvanceCarePlanning**.

What Do I Pay For?

Cost sharing

Cost sharing is when you and your health plan each pay part of the cost for covered services. Your share of these expenses is also known as out-of-pocket costs. All cost sharing is based on your health plan's allowed amount for covered services. Cost sharing may include copays, deductibles and coinsurance, which are defined below. These costs are in addition to your monthly premium, which is the amount you pay each month for health coverage. Your cost-sharing responsibilities reset at the beginning of each benefit period, which is January 1st each year in most cases.

Deductible

A deductible is the fixed amount you pay for medical costs each year before your health plan starts paying its share. Generally, services such as hospital admissions, MRIs and other services that don't require copays count toward your deductible. Once you have paid your deductible for the year, your plan benefits start. You will then only pay your copays or, if applicable, coinsurance. If you have a high-deductible health plan that qualifies for a health savings account, all medical costs count toward your deductible before your plan benefits start. Copays and coinsurance, if applicable, start after the deductible is met.

Copay

A copay is a fixed amount you pay each time you receive certain services. These may include visiting your doctor, seeing a specialist and filling a prescription. Copays do not count toward the deductible. You will continue to pay copays after you have met your deductible until you reach your out-of-pocket limit. Grandfathered plans may not include an out-of-pocket limit.

Coinsurance

Generally coinsurance applies to the same services that count toward your deductible. Coinsurance is a percentage you pay when you get a covered service after your deductible has been met. For example: Your plan pays 80% of the allowed amount for a covered service. The remaining 20% of the allowed amount is the coinsurance amount you pay for the covered service. Not all plans have coinsurance.

Out-of-pocket limit

Some health plans have a limit on the amount you'll have to pay out-of-pocket during a benefit period (usually a calendar year). All copays, coinsurance and deductible amounts count toward the out-of-pocket limit. Once you reach your out-of-pocket limit, your plan pays 100% of the allowed amount for covered services for the remainder of the benefit period. The out-of-pocket limit doesn't include your monthly premium or services that aren't covered.

Cost-sharing and out-of-pocket limit amounts are specific to your benefits package. You can find this information by logging on to **hap.org** and clicking on *My Benefits*. If you have questions or want to request a copy of your plan documents, please call Customer Service.

Premiums – family and individual plan members

Initial premium payment

A premium is the amount you pay each month for your health insurance. Your initial payment must be received and processed **before 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.

Monthly payment processing

Once you receive your HAP member ID, you can log in at **hap.org** and:

- Set up automatic monthly payments.
- Log in monthly to pay your premium online.

Automatic payments are processed on or around the 26th of each month. When the payment date falls on a weekend or holiday, payment is withdrawn on the next business day.

Filing claims

A claim is the bill your health care provider sends to HAP once you receive a service. When you visit a provider for covered services, you should pay only amounts that go toward your copay, deductible or coinsurance. If you get a bill for items other than these cost-sharing amounts, please call Customer Service so they may assist you with resolving this matter.

You shouldn't get bills from providers for medical charges beyond your control. For example, if you get emergency care from a provider not in our network, this is beyond your control.

How to request a reimbursement

Providers who don't have a contract with HAP may require you to pay in advance. In this case, you can request reimbursement within 12 months of the date of covered services. You'll need to submit proof of payment, an itemized bill and a completed Direct Member Reimbursement form. To find the form, log on at **hap.org**, look under *My Forms & Documents*.

The bill from the provider must include:

- Patient's name and ID card number
- Date of service
- Amount charged for each service
- Procedure and diagnosis codes
- Provider's name, address and tax ID number

Send requests for reimbursement to:

HAP Claims Division
Attention: Member Reimbursement
2850 West Grand Blvd.
Detroit, MI 48202

Explanation of Benefits

After we process your claim, you'll get an Explanation of Benefits. The EOB isn't a bill. It's an explanation of how your claim was processed. You can visit **hap.org/eobstatement** to see a video on EOBs. The EOB shows:

- Amount billed by your provider
- Amount we paid
- Your copay or coinsurance amounts
- Amounts applied to your deductible
- Services that were not covered

If you have questions about your EOB or how a claim was paid, call Customer Service. You may also view your EOBs, get claim processing details or sign up for paperless EOBs by logging in at **hap.org**.

Find Information and Manage Your Account

Your hap.org online member account

How to register at hap.org

To get started, get your member ID card and follow these steps:

- Go to **hap.org**.
- Click *Log In* then select *Register Now*.
- Select *Member*.
- Fill out member registration form.
- Click *Submit*.

Explore benefits, manage your account, access services

Once you log in to **hap.org**, you can:

Find plan information and manage your account

- See your plan documents.
- Look up your copays, coinsurance or deductibles.
- Check the status of a claim.
- Review your referrals, authorizations, claims, Explanation of Benefits forms and prescription history.
- Print member ID cards or request them by mail.
- Communicate with our Customer Service team by secure private message.
- Manage auto pay, invoices and payments (individual and family plans).

Manage your health care

- Search for a doctor or facility.
- Find a pharmacy.
- Use telehealth services to talk to a doctor online 24/7.
- Use our Health Care Cost Estimator to estimate your out-of-pocket costs.
- Get reminders for immunizations and screenings.
- Find general drug information such as common side effects.

Access HAP's health and wellness resources and programs

- Learn about services such as our care management, mental health and substance abuse, smoking cessation and weight management programs.
- Use our iStrive® for Better Health digital wellness manager. This easy-to-use interactive tool can help you make smart choices to help you reach your health goals.
- Register for member wellness events.
- Get HAP Member Discounts* on health and wellness programs and services.

HAP OnTheGo mobile ID card app

The HAP OnTheGo mobile ID card app is a smartphone app that makes it easy to:

- **Find a doctor, facility or pharmacy.**
- **View the ID cards of everyone on your plan.**
- **View contact information for HAP Customer Service.**
- **Share your ID card via email or fax.**

The HAP OnTheGo mobile ID card app is free and available at the iTunes and Google Play app stores.

How HAP Ensures Quality Care

HAP's quality program ensures all our members get the highest quality health care. This means that medical and behavioral health services are safe and effective, based on patients' needs and delivered efficiently, fairly and when they're needed.

We constantly assess the program to find out what's working well and where we need to improve. Here are some of the questions we study:

- Are our members getting the right kind of care, in the right place and at the right time?
- Are they satisfied with their care?
- Are our members up-to-date on screenings, vaccinations and other services needed to keep them healthy?
- How well are our members managing chronic diseases like diabetes and heart failure?
- Do our members and providers understand important guidelines that are based on medical research and evidence?
- How well do our hospitals perform on certain quality and safety measures?
- What else can we do to make sure our members have access to the highest quality health care, programs and services to keep them healthy and safe?

Read the annual Quality Program document

The Health Alliance Plan (HAP) Quality Program aims to assure that safe, effective, patient-centered, timely, efficient, and equitable clinical care and services are provided to its members. Our Quality Management Department manages our Quality Program which monitors and improves the health care and services you receive.

We summarize our objectives and progress in our quality program report. You can view it at **hap.org/protecting-your-health**. Click on *HAP's quality program,* and then click *goals and objectives.*

Members without Internet access can contact Customer Service at **(866) 766-4709 (TTY: 711)** and request to speak with the Quality Management Department.

Assessing new medical developments

Health care is a constantly evolving field. And we constantly evaluate new drugs, tests, treatments and technology so you get the best medical care possible. We make changes to our benefits and coverage when new developments will benefit our members.

How we determine what should be covered:

1. The medical policy team compiles all available information into a full report. This includes evaluations and input from health care professionals who are topic experts.
2. We review the report to see if the new advancement is good for our members.
3. Our Benefit Advisory Committee reviews the advancement to decide if it will become a new benefit. All benefit policy rulings are reviewed and finalized by medical professionals.

HAP doctors

Our standards

All HAP doctors, both primary care physicians and specialists, go through a credentialing process. This process ensures they meet our education and training standards. We look at state licenses to make sure doctors meet HAP and state guidelines. We monitor this information and re-credential our doctors at least every three years.

When you're choosing a doctor, this background information may help you make an educated choice and give you peace of mind.

Fair pay

Partnering with our doctors includes making sure they receive fair compensation for services. Our providers receive payment in two ways:

Fee-for-service – Each time you're seen for medical care, we get a bill. We pay the doctor according to a set fee schedule that we establish and that the doctor accepts in advance.

Capitation – The provider is paid a set amount every month, regardless of how much care you receive.

Both methods are based on actual payment practices used throughout the U.S.

Your Rights and Responsibilities

Filing an appeal, grievance or complaint

The Appeal and Grievance Policy explains what to do if you are not satisfied with the services, benefits or policies of HAP or its providers.You always have the right to appeal decisions made about our benefits, claims, billing or services. You also have the right to file a complaint (see Page 3: Contact us). And, depending on your plan, you may also have the right to request an external independent review.

You or your authorized representative may file a request for an expedited external review, with the DIFS, at the same time you file a request for an expedited appeal with us. If this happens and DIFS accepts the external review request, you are considered to have exhausted our internal appeal process.

Purpose

This process provides any Alliance member or the member's authorized representative a way to find a solution to a situation where the member is not satisfied or feels wronged by the services, benefits or policies and procedures of Alliance or its providers or receives an adverse benefit determination (collectively "appeal process"). This policy applies to both preservice and post-service appeals.

Summary

You have the right to file an appeal when you receive a denial for payment or services or if your coverage is cancelled (rescinded) for certain reasons. If you are in an individual plan, you have a one-level appeal process. If you are in a group plan, you have a two-level appeal process.

You, your authorized representative or your health care practitioner may start the appeal process by sending a request in writing to:

Alliance Health and Life Insurance Company
Attention: Manager of Appeal and Grievance Department
2850 W. Grand Blvd.
Detroit, MI 48202

Submit by Fax: **(313) 664-5866**
Submit by Email: **appealsandgrievance@hap.org**
Submit in person: 2850 W. Grand Blvd., Detroit, MI 48202

You may receive this policy in an alternative language (Arabic, Farsi, Spanish or another language) by contacting our Customer Service department at the number listed in this policy.

You may submit an appeal in writing within 180 days from the date you receive the initial denial. If you are in a group plan, you may submit a request for your second-level appeal within 60 days from the date of the level-one appeal decision.

You should include any extra information such as:

- Medical evaluation report
- Medical records
- A copy of your bill
- Your explanation of benefits
- Other important facts to support the request

Once we receive the appeal, we will send a letter telling you that we have accepted the appeal. We have 30 calendar days for preservice appeals, and 60 calendar days for post-service appeals, to make a final determination if you are an individual plan member. Individual members have a one-step internal appeal process. If you are a group member, we have 15 calendar days for preservice appeals, and 60 calendar days for post-service appeals, to make a decision at each level. Group plan members have a two-step internal appeal process.

If you approve our request for an extension of time, we may take up to 10 additional business days for review if we have not received necessary and requested information from a health care facility or health professional. Additional extensions are available to you upon your request. If we go past the allowable time frame, you can go straight to the state for an external review.

We also offer an expedited appeal process where we will make a decision within 72 hours. You may make a request for an expedited appeal if you believe that waiting for the routine timeframe for an internal appeal would seriously threaten you, your health or your ability to regain maximum function. We will ask an appropriate health care practitioner, usually a physician, to review the request and decide if your medical condition needs a decision within 72 hours. If your physician makes the request for an expedited appeal or indicates that you need an expedited appeal, we will provide you with a decision within 72 hours.

You are permitted to have continued coverage during the expedited appeal process for approved ongoing courses of treatment pending the outcome of an internal appeal.

You or your authorized representative may file a request for an expedited external review, with the DIFS, at the same time you file a request for an expedited appeal with us. If this happens and DIFS accepts the external review request, you are considered to have exhausted our internal appeal process. You or your authorized representative may file a request for an external review with the DIFS if we:

- Fail to comply with the requirements of our internal appeal policy, unless the failure is based on a trivial or minor violation that does not cause prejudice or harm to you.
- Fail to issue a written decision to you or your authorized representative within the required time, and without you requesting or agreeing to an extension.
- Waive our internal appeal process and the requirement for you to exhaust the process before filing a request for an external review. If this happens, and DIFS accepts your request for an external review, you are considered to have exhausted our internal appeal process.

When filing for a request for an external review, you will be required to authorize the release of medical records that may be required to be reviewed to reach a decision on the external review.

You will not have to bear any costs for an external review, including any filing fees.

You may request and receive, at no cost, copies of documents, records and other information relevant to your appeal. During the internal appeal process, you or your authorized representative have the option to present the appeal in person, by phone or using other ways of communication. Individual plan members may present their one level appeal to one of our designated appeals persons. Group plan members may present their appeal to an appeals committee at their second-level appeal.

A health care practitioner who has appropriate training and experience in the field of medicine involved in your case will review the appeal if the initial denial was based on medical necessity.

People who were involved in the initial denial will not be included in making the decision for the appeal. People who were involved in a level-one appeal for a group member will not be included in making a decision for a level-two appeal. Before your internal appeal may be denied based on a new or additional rationale, or any new or additional evidence considered, relied upon, or generated in connection with the appeal, you will be provided with the new rationale or evidence to you, at no cost, within a sufficient amount of time to allow you a reasonable opportunity to respond to the new rationale or evidence. This information will be provided to you before you are provided with a final determination on your appeal.

If you are still not satisfied with the final decision after the internal appeal process or if you meet the requirements for an external review, as described above, you can ask for an external review under the Patient's Right to Independent Review Act. After you receive the final decision or exhaust the internal appeal process, you can request an external review by contacting the director of the DIFS within 127 days by writing to:

Department of Insurance and Financial Services Healthcare Appeals Section

Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720
You may also call the director at **(877) 999-6442**.

We will automatically provide you with the FIS 0018 (4/13) – Health Care Request for External Review form after the final appeal decision. This form is necessary to ask for an external review. You can also get a copy of the form anytime by going to the DIFS website *https://difs.state.mi.us/Complaints/ExternalReview.aspx*. You can also call the number listed below and ask for the form.

Protecting your health information

Safeguarding the privacy of your protected health information, or PHI, is important to HAP. PHI is information about you that can reasonably be used to identify you. This includes your name, demographic data and member ID number. It includes information about your past, present or future physical or mental health, care and treatment you receive and payment for care.

The Notice of Privacy Practices explains how we use information about you and when we can share that information with others. It also tells you about your rights with respect to your PHI and how you can use your rights.

You can read the full Notice of Privacy Practices in the appendix.

Patient protection laws

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act, passed in 2008, protects people against unfair treatment if DNA traits raise their chances of getting an illness. For example, it means health insurers can't refuse to cover a member whose DNA suggests that their breast cancer risk is higher than average. It also means employers can't hire or fire workers based on their DNA information.

Michelle's Law

Passed in 2010, this law was designed to keep college students from losing their parents' group health insurance if they drop out of school because of illness. It's named after Michelle Morse, who became a student health rights advocate after being diagnosed with cancer in her college years. The law says employer-provided health plans must continue coverage for up to one year if a dependent child who is a college student takes a "certified medically necessary leave of absence."

Why we ask about race and ethnicity

We, and your doctors, may ask you questions about your race and ethnicity. We may ask what languages you speak. Giving us this information is voluntary. Any information you provide is confidential. This information helps us create programs to meet all our members' needs. It isn't used to decide your coverage, costs or claims. It isn't used to discriminate against you in any way.

We appreciate any help you give us to improve and expand our services. When we work together, we can help improve the quality of life for our entire membership.

Member rights and responsibilities

As a member, you have the right to:

- Get complete information about your health plan, including our services, practitioners and providers – and your rights and responsibilities.
- Get private, thoughtful and respectful care. Care does not take nationality, race, creed, color, age, economic rank, gender or lifestyle into consideration.
- Work with your doctors in making choices about your health care. Talk to your doctor to fully understand your illness or treatment.
- Have a candid talk with your providers about your treatment alternatives, no matter the cost or benefit coverage.
- Be provided with all the information you need to give informed, legally needed consent before the start of any procedure or treatment. This includes an explanation of procedures and any risks.
- Voice a complaint about us or appeal our services.
- Make recommendations about our members' rights and responsibilities policies.
- Be told about affiliated providers available for medical care.
- Expect us to make a reasonable answer to your requests.
- Get prompt care in an emergency.

As a member, you have the responsibility to:

- Make your medical history and symptoms known before and during treatment.
- Tell us of any changes in important membership information.
- Tell your doctor of any unexpected changes in your health.
- Follow the plans and directions for care that you agreed on with your providers.
- Understand your health problems.
- Take part in creating mutually agreed-upon treatment goals, to the degree possible.
- Cooperate fully with your providers.
- Understand our procedures, and use the plan in the right way.
- Respect the rights of other patients and members.

Notice of Privacy Practices

This notice describes how protected health information that is about you may be used and disclosed and how you gain access to this information.

Health Alliance Plan | Alliance Health and Life Insurance Company | HAP Empowered Health Plan, Inc. Last review: Oct. 1, 2018

Your protected health information

PHI stands for protected health information. PHI is information that can be used to identify you. It includes information such as your name, age, sex, address and member ID number, as well as your:

- Physical or mental health
- Health care services
- Payment for care

You can ask HAP to give your PHI to people you choose. To do this, fill out our release form. You can find it at **hap.org/privacy**.

Your privacy

Keeping your PHI safe is important to HAP. We're required by law to keep your PHI private. We must also tell you about our legal duties and privacy practices. This notice explains:

- How we use information about you
- When we can share it with others
- Your rights related to your PHI
- How you can use your rights

When we use the term "HAP," "we" or "us" in this notice, we're referring to HAP and its subsidiaries, including Alliance Health and Life Insurance Company and HAP Empowered Health Plan, Inc.

How we protect your PHI

We protect your PHI in written, spoken and electronic form. Our employees and others who handle your information must follow our policies on privacy and technology use. Anyone who starts working for HAP must state that they have read these policies. And they must state that they will protect your PHI even after they leave HAP. Our employees and contractors can only use the PHI necessary to do their jobs. And they may not use or share your information except in the ways outlined in this notice.

How we use or share your PHI

We only share your information with those who must know for:

- Treatment
- Payments
- Business tasks

Treatment

We may share your PHI with your doctors, hospitals or other providers to help them:

- Provide treatment. For example, if you're in the hospital, we may let them see records from your doctor.
- Manage your health care. For example, we might talk to your doctor to suggest a HAP program that could help improve your health.

Payment

We may use or share your PHI to help us figure out who must pay for your medical bills. We may also use or share your PHI to:

- Collect premiums
- Determine which benefits you can get
- Figure out who pays when you have other insurance

Business tasks

As allowed by law, we may share your PHI with:

- Companies affiliated with HAP
- Other companies that help with HAP's everyday work
- Others who help provide or pay for your health care

We may also share your information with others who help us do business. If we do, they must keep your information private and secure. And they must return or destroy it when they no longer need it for our business.

It may be used to:

- Evaluate how good care is and how much it improves. This may include provider peer review.
- Make sure health care providers are qualified and have the right credentials.
- Review medical outcomes.
- Review health claims.
- Prevent, find and investigate fraud and abuse.
- Decide what is covered by your policy and how much it will cost. But, we are not allowed to use or share genetic information to do that.
- Do pricing and insurance tasks.
- Help members manage their health care and get help managing their care.
- Communicate with you about treatment options or other health-related benefits and services.
- Do general business tasks, such as quality reviews and customer service.

Other permitted uses

We may also be permitted or required to share your PHI:

With you

- To tell you about medical treatments and programs or health-related products and services that may interest you. For example, we might send you information on how to stop smoking or lose weight.
- For health reminders, such as refilling a prescription or scheduling tests to keep you healthy or find diseases early.
- To contact you, by phone or mail, for surveys. For example, each year we ask our members about their experience with HAP.

With a friend or family member

- With a friend, family member or other person who, by law, may act on your behalf. For example, parents can get information about their children covered by HAP.
- With a friend or family member in an unusual situation, such as a medical emergency, if we think it's in your best interests. For example, if you have an emergency in a foreign country and can't contact us directly. In that case, we may speak with a friend or family member who is acting on your behalf.
- With someone who helps pay for your care. For example, if your spouse contacts us about a claim, we may tell him or her whether the claim has been paid.

With the government

- For public health needs in the case of a health or safety threat such as disease or a disaster.
- For U.S. Food and Drug Administration investigations. These might include probes into harmful events, product defects or product recalls.
- For health oversight activities authorized by law.
- For court proceedings and law enforcement uses.
- With the police or other authority in case of abuse, neglect or domestic violence.
- With a coroner or medical examiner to identify a body, find out a cause of death or as authorized by law. We may also share member information with funeral directors.
- To comply with workers' compensation laws.
- To report to state and federal agencies that regulate HAP and its subsidiaries. These may include the:
  - U.S. Department of Health and Human Services
  - Michigan Department of Insurance and Financial Services
  - Michigan Department of Health and Human Services
  - Federal Centers for Medicare and Medicaid Services
  - To protect the U.S. president

For research or transplants

- For research purposes that meet privacy standards. For example, researchers want to compare outcomes for patients who took a certain drug and must review a series of medical records.
- To receive, bank or transplant organs, eyes or tissue.

With your employer or plan sponsor

We may use or share your PHI with an employee benefit plan through which you get health benefits. It is only shared when the employer or plan sponsor needs it to manage your health plan. Except for enrollment information or summary health information and as otherwise required by law, we only share your PHI with an employer or plan sponsor if they have guaranteed in writing that it will be kept private and won't be used improperly.

To use or share your PHI for any other reason, we must get your written permission. If you give us permission, you may change your mind and cancel it. But it will not apply to information we've already shared.

Organized health care arrangement

HAP and HAP affiliates covered by this Notice of Privacy Practices and Henry Ford Health System and its affiliates are part of an organized health care arrangement. Its goal is to deliver higher quality health care more efficiently and to take part in quality measure programs, such as the Healthcare Effectiveness Data and Information Set. HEDIS is a set of standards used to measure the performance of a health plan. In other words, HEDIS is a report card for managed care plans.

The Henry Ford Health System organized health care arrangement includes:

- HAP
- Alliance Health and Life Insurance Company
- HAP Empowered Health Plan, Inc.
- HAP Preferred, Inc.
- Henry Ford Health System

Henry Ford's organized health care arrangement lets these organizations share PHI. This is only done if allowed by law and when needed for treatment, payment or business tasks relating to the organized health care arrangement.

This list of organizations may be updated. You can access the current list at **hap.org/privacy** or call us at **(800) 422-4641 (TTY: 711)**. When required, we will tell you about any changes in a revised Notice of Privacy Practices.

Your rights

These are your rights with respect to your information. If you would like to exercise any of these rights, please contact us. The contact information is in the "Who to contact" section at the end of this document. You may have to make your requests in writing.

You have the following rights:

Right to see your PHI and get a copy

With some exceptions, you have the right to see or get a copy of PHI in records we use to make decisions about your health coverage. This includes our enrollment, payment, claims resolutions and case or medical management notes. If we deny your request, we'll tell you why and whether you have a right to further review.

You may have to fill out a form to get PHI and pay a fee for copies. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to ask us to change your PHI

If we deny your request for changes in PHI, we'll explain why in writing. If you disagree, you may have your disagreement noted in our records. If we accept your request to change the information, we'll make reasonable efforts to tell others of the change, including people you name. In this case, the information you give us must be correct. And we cannot delete any part of a legal record, such as a claim submitted by your doctor.

Right to know about disclosures

You have the right to know about certain disclosures of your PHI. HAP does not have to inform you of all PHI we release. We are not required to tell you about PHI shared or used for treatment, payment and business tasks. And we do not have to tell you about information we shared with you or based on your authorization. But you may request a list of other disclosures made during the six years prior to your request.

Your first list in any 12-month period is free. However, if you ask for another list within 12 months of receiving your free list, we may charge you a fee. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to know about data breaches that compromise your PHI

If there is a breach of your unsecured PHI, we'll tell you about it as required by law or in cases when we deem it appropriate.

Right to ask us to limit how we use or share your PHI

You may ask us to limit how we use or share your PHI for treatment, payment or business tasks. You also have the right to ask us to limit PHI shared with family members or others involved in your health care or payment for it. We do not have to agree to these limits. But if we do, we'll follow them – unless needed for emergency treatment or the law requires us to share your PHI. In that case, we will tell you that we must end our agreement.

Right to request private communications

If you believe that you would be harmed if we send your PHI to your current mailing address (for example, in a case of domestic dispute or violence), you can ask us to send it another way. We can send it by fax or to another address. We will try to meet any fair requests.

You have a right to get a paper copy of this notice.

See our contact information below.

Changes to the privacy statement

We have the right to make changes to this notice. If we make changes, the new notice will be effective for all the PHI we have. Once we make changes, we'll send you the new notice by U.S. mail and post it on our website.

Who to contact

If you have any questions about this notice or about how we use or share member information, mail a written request to:

HAP and HAP Empowered Health Plan, Inc. Information Privacy & Security Office
One Ford Place, 2A
Detroit, MI 48202

You may also call us at **(800) 422-4641 (TTY: 711).**

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us. Contact the Information Privacy & Security Office above or HAP's Compliance Hotline at **(877) 746-2501 (TTY: 711)**. You can stay anonymous. You may also notify the secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Appeal and grievance rights

Alliance Health and Life Insurance company commercial group and individual appeal policy

Purpose

This policy provides any Alliance member or the member's authorized representative a way to find a solution to a situation where the member is not satisfied or feels wronged by the services, benefits or policies and procedures of Alliance or its providers or receives an adverse benefit determination (collectively "appeal process"). This policy applies to both preservice and post-service appeals.

Summary

The policy allows you to file an appeal when you receive a denial for payment or services or if your coverage is cancelled (rescinded) for certain reasons. If you are in an individual plan, you have a one-level appeal process. If you are in a group plan, you have a two-level appeal process.

You, your authorized representative or your health care practitioner may start the appeal process by sending a request in writing to:

Alliance Health and Life Insurance Company
Attention: Manager of Appeal and Grievance Department
2850 W. Grand Blvd. Detroit, MI 48202

Submit by Fax: **(313) 664-5866**

Submit by Email: **appealsandgrievance@hap.org**

Submit in person: 2850 W. Grand Blvd., Detroit, MI 48202

You may receive this policy in an alternative language (Arabic, Farsi, Spanish or another language) by contacting our Customer Service department at the number listed in this policy.

You may submit an appeal in writing within 180 days from the date you receive the initial denial. If you are in a group plan, you may submit a request for your second-level appeal within 60 days from the date of the level-one appeal decision.

You should include any extra information such as:

- Medical evaluation report
- Medical records
- A copy of your bill
- Your explanation of benefits
- Other important facts to support the request

Once we receive the appeal, we will send a letter telling you that we have accepted the appeal. We have 30 calendar days for preservice appeals, and 60 calendar days for post-service appeals, to make a final determination if you are an individual plan member. Individual members have a one-step internal appeal process. If you are a group member, we have 15 calendar days for preservice appeals, and 60 calendar days for post-service appeals, to make a decision at each level. Group plan members have a two-step internal appeal process.

If you approve our request for an extension of time, we may take up to 10 additional business days for review if we have not received necessary and requested information from a health care facility or health professional. Additional extensions are available to you upon your request. If we go past the allowable time frame, you can go straight to the state for an external review. If you are a member of a group plan subject to the Employee Retirement Income Security Act, or ERISA, you may bring a lawsuit under section 502(a) of ERISA. Ask your employer if you are part of an ERISA group plan.

We also offer an expedited appeal process where we will make a decision within 72 hours. You may make a request for an expedited appeal if you believe that waiting for the routine timeframe for an internal appeal would seriously threaten you, your health or your ability to regain maximum function. We will ask an appropriate health care practitioner, usually a physician, to review the request and decide if your medical condition needs a decision within 72 hours. If your physician makes the request for an expedited appeal or indicates that you need an expedited appeal, we will provide you with a decision within 72 hours.

You are allowed to have continued coverage during the expedited appeal process for approved ongoing courses of treatment pending the outcome of an internal appeal.

You or your authorized representative may file a request for an expedited external review, with the DIFS, at the same time you file a request for an expedited appeal with us. If this happens and DIFS accepts the external review request, you are considered to have exhausted our internal appeal process.

You or your authorized representative may file a request for an external review with the DIFS if we:

- Fail to comply with the requirements of our internal appeal policy, unless the failure is based on a trivial or minor violation that does not cause prejudice or harm to you
- Fail to issue a written decision to you or your authorized representative within the required time, and without you requesting or agreeing to an extension
- Waive our internal appeal process and the requirement for you to exhaust the process before filing a request for an external review

If this happens, and DIFS accepts your request for an external review, you are considered to have exhausted AHL's internal appeal process. When filing for a request for an external review, you will be required to authorize the release of medical records that may be required to be reviewed to reach a decision on the external review.

You will not have to bear any costs for an external review, including any filing fees.

You may request and receive, at no cost, copies of documents, records and other information relevant to your appeal.

During the internal appeal process, you or your authorized representative have the option to present the appeal in person, by phone or using other ways of communication. Individual plan members may present their one level appeal to one of our designated appeals persons. Group plan members may present their appeal to an appeals committee at their second-level appeal.

A health care practitioner who has appropriate training and experience in the field of medicine involved in your case will review the appeal if the initial denial was based on medical necessity.

People who were involved in the initial denial will not be included in making the decision for the appeal. People who were involved in a level-one appeal for a group member will not be included in making a decision for a level-two appeal.

Before your internal appeal may be denied based on a new or additional rationale, or any new or additional evidence considered, relied upon, or generated in connection with the appeal, you will be provided with the new rationale or evidence to you, at no cost, within a sufficient amount of time to allow you a reasonable opportunity to respond to the new rationale or evidence. This information will be provided to you before you are provided with a final determination on your appeal.

If you are still not satisfied with the final decision after the internal appeal process or if you meet the requirements for an external review, as described above, you can ask for an external review under the Patient's Right to Independent Review Act. After you receive the final decision or exhaust the internal appeal process, you can request an external review by contacting the director of the DIFS within 127 days by writing to:

Department of Insurance and Financial Services Healthcare Appeals Section
Office of General Counsel
Box 30220
Lansing, MI 48909-7720

You may also call the director at **(877) 999-6442**.

We will automatically provide you with the FIS 0018 (4/13) – Health Care Request for External Review form after the final appeal decision. This form is necessary to ask for an external review. You can also get a copy of the form anytime by going to the DIFS website **https://difs.state.mi.us/Complaints/ExternalReview.aspx**. You can also call the number listed below and ask for the form.

Other rights:

If you are a member of a group plan subject to ERISA, you may bring a lawsuit under section 502(a) of ERISA if you have exhausted our internal appeal process. Ask your employer if you are part of an ERISA Group Plan.

For more information:

Members can call Customer Service at **(888) 999-4347**.

Call the DIFS directly at the number listed above or visit their website at **michigan.gov/difs**.

For assistance you may contact the Michigan Health Insurance Consumer Assistance Program, 530 W. Allegan St., Seventh floor, Lansing, MI 48933 at **(877) 999-6442** or email at **DIFS-HICAP@Michigan.gov**.

HAP commercial group and individual appeal policy

Purpose

This policy provides any HAP member or the member's authorized representative a way to find a solution to a situation where the member is not satisfied or feels wronged by the services, benefits or policies and procedures of HAP or its providers or receives an adverse benefit determination (collectively "appeal process"). This policy applies to both preservice and post-service appeals.

Summary

The policy allows you to file an appeal when you receive a denial for payment or services or if your coverage is cancelled (rescinded) for certain reasons. Our HMO and PPO Individual plan members have a one-level appeal process. If you are in a group plan, there is a two-level appeals process.

Starting the appeal process

You, your authorized representative or your health care practitioner may start the appeal process by sending a request in writing to:

HAP
Attention: Manager of Grievance Department
2850 W. Grand Blvd.
Detroit, MI 48202

Submit by Fax: **(313) 664-5866**

Submit by Email: **appealsandgrievance@hap.org**

Submit in person: 2850 W. Grand Blvd., Detroit, MI 48202 or 2050 S. Linden Road, Flint, MI 48532

You may receive this policy in an alternative language (Arabic, Farsi, Spanish or another language) by contacting our Customer Service department at the number listed in this policy.

You may submit an appeal in writing within 180 days from the date you receive the initial denial. If you are in a group plan, you may submit a request for your second-level appeal within 60 days from the date of the first-level appeal decision.

What you need to submit

You should include all information, including:

- Medical evaluation report
- Medical records
- A copy of your bill
- Your Explanation of Benefits
- Other important facts to support the request

Appeal Timeline

Once we receive the appeal, we will send a letter telling you that we have accepted the appeal. We have 30 calendar days for preservice appeals, and 60 calendar days for post-service appeals, to make a final determination if you are an individual plan member. Individual members have a one-step internal appeal process. If you are a group member, we have 15 calendar days for preservice appeals and 60 calendar days for post-service appeals, to make a decision at each level. Group plan members have a two-step internal appeal process.

Extensions

If we request additional time and you approve our request for an extension, we may take up to 10 additional business days for review if we have not received necessary and requested information from a health care facility or health professional. Additional extensions are available to you upon your request. If we go past the allowable time frame, you can go straight to the state of Michigan for an external review. Or if you are a member of a group plan subject to the Employee Retirement Income Security Act you may bring a lawsuit under section 502(a) of ERISA. Ask your employer if you are part of an ERISA group plan

Requesting an expedited appeal

We also offer an expedited appeal process where we will make a decision within 72 hours. You may make a request for an expedited appeal if you believe that waiting for the routine timeframe for an internal appeal would seriously threaten you, your health or your ability to regain maximum function. We will ask an appropriate health care practitioner, usually a physician, to review the request and decide if your medical condition needs a decision within 72 hours. If your physician makes the request for expedited external review, expedited appeal or indicates that you need an expedited appeal, we will provide you with a decision within 72 hours.

You are allowed to have continued coverage during the expedited appeal process for approved ongoing courses of treatment pending the outcome of an internal appeal.

Requesting an expedited external review

You or your authorized representative may file a request for an expedited external review, with the Department of Insurance and Financial Services, at the same time you file a request for an expedited appeal with us. If this happens and DIFS accepts the external review request, you are considered to have exhausted our internal appeal process.

You or your authorized representative may file a request for an external review with the DIFS if we:

- Fail to comply with the requirements of our internal appeal policy, unless the failure is based on a trivial or minor violation that does not cause prejudice or harm to you
- Fail to issue a written decision to you or your authorized representative within the required time, and without you requesting or agreeing to an extension
- Waive our internal appeal process and the requirement for you to exhaust the process before filing a request for an external review

If this happens, and DIFS accepts your request for an external review, you are considered to have exhausted HAP's internal appeal process. When filing for a request for an external review, you will be required to authorize the release of medical records that may be required to be reviewed to reach a decision on the external review. You will not have to bear any costs for an external review, including any filing fees. You may request and receive, at no cost, copies of documents, records and other information relevant to your appeal.

Internal appeal process

During the internal appeal process, you or your authorized representative have the option to present the appeal in person, by phone or using other ways of communication. Individual plan members may present their one level appeal to one of our designated appeals persons. Group plan members may present their appeal to an appeals committee at their second level appeal.

A health care practitioner who has appropriate training and experience in the field of medicine involved in your case will review the appeal, if the initial denial was based on medical necessity.

People who were involved in the initial denial will not be included in making the decision for the appeal. People who were involved in a level one appeal for a group member will not be included in making a decision for a level two appeal.

Before your internal appeal may be denied based on a new or additional rationale, or any new or additional evidence considered, relied upon, or generated in connection with the appeal, you will be provided with the new rationale and evidence to you, at no cost, within a sufficient amount of time to allow you a reasonable opportunity to respond to the new rationale or evidence. This information will be provided to you before you are provided with a final determination on your appeal.

If you are not satisfied with the results of the internal appeal

If you are still not satisfied with the final decision after the internal appeal process or if you meet the requirements for an external review, as described above, you can ask for an external review under the Patient's Right to Independent Review Act. After you receive the final decision or exhaust the internal appeal process you can request an external review by contacting the Director of DIFS within 127 days by writing to:

Department of Insurance and Financial Services Healthcare Appeals Section
Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720

You may also call the director at **(877) 999-6442**.

We will automatically provide you with the FIS 0018 (4/13) – Health Care Request for External Review form after the final appeal decision. This form is necessary to ask for an external review. You can also get a copy of the form anytime by going to the DIFS website **https://difs. state.mi.us/Complaints/ExternalReview.aspx**. You can also call the number listed below and ask for the form.

Bringing a lawsuit if your employer is part of an ERISA group plan

If you are a member of a group plan subject to ERISA, you may bring a lawsuit under section 502(a) of ERISA if you have exhausted our internal appeal process. Ask your employer if you are part of an ERISA group plan.

For more information:

Members can call HAP Customer Service at **(800) 422-4641 (TTY: 711)**.

Call the DIFS directly at the number listed above or visit their website at michigan.gov/difs.

For assistance you may contact the Michigan Health Insurance Consumer Assistance Program, 530 W. Allegan St., Seventh Floor, Lansing, MI 48933 at **(877) 999-6442** or email at **DIFS-HICAP@Michigan.gov**.

Nondiscrimination Notice

Health Alliance Plan of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. HAP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HAP provides:

- Free aids and services to help people communicate effectively with us:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, others)
- Free language services to people whose primary language is not English:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact HAP's Customer Service manager at **(800) 422-4641**.

If you believe that HAP has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability or sex, you can file a grievance with HAP's director of grievance and appeals. Use the information below:

Mail: 2850 West Grand Blvd., Detroit, Michigan 48202

Phone: **(800) 422-4641 (TTY: 711)**

Fax: **(313) 664-5866**

Email: **appealsandgrievance@hap.org**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Online: Use the Office for Civil Rights' Complaint Portal Assistant at: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

Mail: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Phone: **(800) 368-1019** or **TTY: (800) 537-7697**.

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