Choose HAP and get more from a health plan

We believe health plans should be more than just doctors and deductibles. You want to be listened to, treated well and get unexpected extras that don't cost more. We get it. And we'll always do the best for you and your family.

What to expect from HAP Personal Alliance®

All of our health plans give you access to leading doctors and hospitals. But there's so much more. We have services, features and benefits that other health plans just don't offer. Only HAP provides members with a personal service coordinator. This is a dedicated person to answer questions and help guide you through the first two years of membership.

We also have a process that allows members to transfer out-of-pocket costs to a new HAP Personal Alliance health plan. These are costs you would have already paid out-of-pocket for covered services, medications and medical supplies within a calendar year.* We are the only health plan to offer this process for individual coverage.

Here are some other services and programs we offer:

- **Travel assistance and identity theft protection –** Assist America offers trusted global emergency travel assistance plus free 24/7 identity theft protection to eligible members
- **Restore CareTrack® –** a program to help manage chronic conditions like high blood pressure, diabetes and asthma
- **Member Wellness programs –** health and wellness events, stress management programs, a wide variety of healthy body and mind topics with engaging speakers, and more
- **HAP Advantage program –** member discounts on local gym memberships, Weight Watchers® and other healthy living activities
- **HAP OnTheGo Mobile App –** to help find a doctor or health care facility, check symptoms and get access to your ID card

Vision and dental coverage

Pediatric vision services are covered on every HAP Qualified Health Plan (QHP). This includes an annual routine eye exam and one pair of glasses every calendar year. Adult vision hardware benefits are offered on some plans as well.

As one of the Essential Health Benefits, QHPs purchased directly from HAP can include pediatric dental coverage from Delta Dental. Adult dental benefits are also available.

Cost-sharing

Every health plan is unique. Your benefits and costs depend on which plan you choose. But before choosing a health plan, look beyond the monthly premium to find out what your share of those costs will be. For more information on cost-sharing, visit **chooseHAP.org/healthinsurancebasics**.

For more information about HAP Personal Alliance health plans, please call **(855) WITH HAP (948-4427)**. Or visit **chooseHAP.org**.

* Some restrictions may apply.

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

HAP Personal Alliance Qualified Health Plans

HAP has everything you need right here, in one place. Here's our list of HAP Personal Alliance plan options.

		Deductible (In-network) Individual/ Family	Co-insurance (In-network)	Out-of-Pocket Limit (In-Network) (Individual/Family)	Primary Care Physician/ Specialist Office Visit	Emergency Room/ Urgent Care	Rx-Generic/Preferred Brand/Non-preferred Brand/Specialty
PLATINUM	HAP Personal Alliance 500 HMO *Includes Choice Network Options*	$500/$1,000	20%	$1,500/$3,000	$10/$30	$250/$65	$5/$30/50%/50%
GOLD	HAP Personal Alliance 1500 HMO *Includes Choice Network Options*	$1,500/$3,000	20%	$3,500/$7,000	$15/$30	$250/$65	$15/$60/50%/50%
	HAP Personal Alliance 1500 PPO	$1,500/$3,000	0%	$3,500/$7,000	$15/$30	$250/$65	$15/$60/50%/50%
	HAP Personal Alliance 2000 HMO (HSA) *Includes Choice Network Options*	$2,000/$4,000	0%	$2,000/$4,000	Covered after deductible	Covered after deductible	Covered after deductible
	HAP Personal Alliance 2000 PPO (HSA)	$2,000/$4,000	0%	$2,000/$4,000	Covered after deductible	Covered after in-network deductible	Covered after in-network deductible
SILVER	HAP Personal Alliance 2500 HMO *Choice Networks Only*	$2,500/$5,000	20%	$6,000/$12,000	$30/$50	20% after deductible/$65	$15/$60/50%/50%
	HAP Personal Alliance 2500 HMO	$2,500/$5,000	20%	$6,350/$12,700	$30/$50	$250/$65	$15/$60/50%/50%
	HAP Personal Alliance 2500 PPO	$2,500/$5,000	20%	$6,000/$12,000	$30/$50	20% after in-network deductible/$65	$15/$60/50%/50%
	HAP Personal Alliance 3000 HMO *Includes Choice Network Options*	$3,000/$6,000	20%	$6,000/$12,000	$30/$50	20% after deductible/$65	$15/$60/50%/50%
	HAP Personal Alliance 3000 PPO	$3,000/$6,000	20%	$6,350/$12,700	$30/$50	$250/$65	$15/$60/50%/50%
BRONZE	HAP Personal Alliance 5000 HMO *Choice Networks Only*	$5,000/$10,000	20%	$6,600/$13,200	$40/$60	20% after deductible/$65	$25/$125/50%/50%
	HAP Personal Alliance 5000 HMO	$5,000/$10,000	20%	$6,350/$12,700	$40/$60	$250/$65	$25/$125/50%/50%
	HAP Personal Alliance 5000 PPO	$5,000/$10,000	20%	$6,600/$13,200	$40/$60	20% after in-network deductible/$65	$25/$125/50%/50%
	HAP Personal Alliance 5000 HMO (HSA) *Includes Choice Network Options*	$5,000/$10,000	20%	$6,450/$12,900	20% after deductible	20% after deductible	20% after deductible
	HAP Personal Alliance 5000 PPO (HSA)	$5,000/$10,000	20%	$6,450/$12,900	20% after deductible	20% after in-network deductible	20% after in-network deductible
CATASTROPHIC	Must be under 30 years old or qualify for a hardship exemption. HAP Personal Alliance 6600 HMO *Includes Choice Network Options*	$6,600/$13,200	0%	$6,600/$13,200	Limit of 3 PCP then covered after deductible/ Covered after deductible	Covered after deductible	Covered after deductible
	HAP Personal Alliance 6600 PPO	$6,600/$13,200	0%	$6,600/$13,200	Limit of 3 PCP then covered after deductible/ Covered after deductible	Covered after in-network deductible	Covered after in-network deductible

This chart of HAP Personal Alliance Health Plans is designed to promote an overview of available plans. All plans are subject to the actual terms and conditions of the policy. In the case of a conflict between this chart and a policy, the terms and conditions of the policy govern.

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

PLATINUM

HAP Personal Alliance 500 HMO

Choice Networks

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$500/$1,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$1,500/$3,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$10 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$30 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$30 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$10 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$5/$30/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

PLATINUM

HAP Personal Alliance 500 HMO

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$500/$1,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$1,500/$3,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$10 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$30 copay	Not covered
Diagnostic test (x-ray, lab)	$10 copay	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$30 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$10 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$10 copay	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$10 copay	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$5/$30/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 1500 HMO

Choice Networks

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$1,500/$3,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$3,500/$7,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$15 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$30 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$30 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$15 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 1500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 1500 HMO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$1,500/$3,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$3,500/$7,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$15 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$30 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$30 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$15 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 1500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 1500 PPO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$1,500/$3,000	$5,000/$10,000
COINSURANCE		
Member	0%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$3,500/$7,000	$10,000/$20,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$15 copay	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	$30 copay	50% after deductible
Diagnostic test (x-ray, lab)	$15 copay	50% after deductible
Imaging (CT/PET Scans, MRIs)	Covered after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	Covered after deductible	50% after deductible
Outpatient surgery and related services	Covered after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	$30 copay	50% after deductible
Chiropractic care (20-visit limit)	$30 copay	50% after deductible
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	50% after deductible
Outpatient services	$15 copay	50% after deductible
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	50% after deductible
Hospice services	Covered after deductible	50% after deductible
Skilled nursing facility – 45 days	Covered after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	Covered after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$15 copay	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$15 copay	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 1500 PPO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 2000 HMO (HSA)

Choice Networks

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,000/$4,000	Not applicable
COINSURANCE		
Member	0%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$2,000/$4,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Covered after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	Not covered
Diagnostic test (x-ray, lab)	Covered after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	Covered after deductible	Not covered
Chemotherapy/Dialysis/Radiation	Covered after deductible	Not covered
Outpatient surgery and related services	Covered after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	Not covered
Chiropractic care (20-visit limit)	Covered after deductible	Not covered
Emergency Services		
Emergency room services	Covered after deductible	
Urgent care centers or facilities	Covered after deductible	
Emergency transport/ambulance	Covered after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	Not covered
Outpatient services	Covered after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	Not covered
Hospice services	Covered after deductible	Not covered
Skilled nursing facility – 45 days	Covered after deductible	Not covered
Durable medical equipment/Prosthetic devices	Covered after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2000 HMO (HSA) Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 2000 HMO (HSA)

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,000/$4,000	Not applicable
COINSURANCE		
Member	0%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$2,000/$4,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Covered after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	Not covered
Diagnostic test (x-ray, lab)	Covered after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	Covered after deductible	Not covered
Chemotherapy/Dialysis/Radiation	Covered after deductible	Not covered
Outpatient surgery and related services	Covered after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	Not covered
Chiropractic care (20-visit limit)	Covered after deductible	Not covered
Emergency Services		
Emergency room services	Covered after deductible	
Urgent care centers or facilities	Covered after deductible	
Emergency transport/ambulance	Covered after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	Not covered
Outpatient services	Covered after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	Not covered
Hospice services	Covered after deductible	Not covered
Skilled nursing facility – 45 days	Covered after deductible	Not covered
Durable medical equipment/Prosthetic devices	Covered after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2000 HMO (HSA) Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

GOLD

HAP Personal Alliance 2000 PPO (HSA)

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,000/$4,000	$4,000/$8,000
COINSURANCE		
Member	0%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$2,000/$4,000	$8,000/$16,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Covered after deductible	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	50% after deductible
Diagnostic test (x-ray, lab)	Covered after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	Covered after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	Covered after deductible	50% after deductible
Outpatient surgery and related services	Covered after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	50% after deductible
Chiropractic care (20-visit limit)	Covered after deductible	50% after deductible
Emergency Services		
Emergency room services	Covered after in-network deductible	
Urgent care centers or facilities	Covered after in-network deductible	
Emergency transport/ambulance	Covered after in-network deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	50% after deductible
Outpatient services	Covered after deductible	50% after deductible
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	50% after deductible
Hospice services	Covered after deductible	50% after deductible
Skilled nursing facility – 45 days	Covered after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	Covered after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after in-network deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2000 PPO (HSA) Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 2500 HMO

Choice Networks

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,500/$5,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,000/$12,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$50 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$30 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 2500 HMO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,500/$5,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,350/$12,700	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	Not covered
Diagnostic test (x-ray, lab)	$50 copay	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$50 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$30 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$50 copay	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$50 copay	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2500 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 2500 PPO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$2,500/$5,000	$5,000/$10,000
COINSURANCE		
Member	20%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$6,000/$12,000	$12,000/$24,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	50% after deductible
Diagnostic test (x-ray, lab)	20% after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	20% after deductible	50% after deductible
Outpatient surgery and related services	20% after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	$50 copay	50% after deductible
Chiropractic care (20-visit limit)	$30 copay	50% after deductible
Emergency Services		
Emergency room services	20% after in-network deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after in-network deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	50% after deductible
Outpatient services	$30 copay	50% after deductible
Ancillary Services		
Home health care services – 100 visits	20% after deductible	50% after deductible
Hospice services	20% after deductible	50% after deductible
Skilled nursing facility – 45 days	20% after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	20% after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 2500 PPO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 3000 HMO

Choice Networks

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$3,000/$6,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,000/$12,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$50 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$30 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 3000 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 3000 HMO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$3,000/$6,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,000/$12,000	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$50 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$30 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 3000 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 3000 PPO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$3,000/$6,000	$6,000/$12,000
COINSURANCE		
Member	20%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$6,350/$12,700	$12,000/$24,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$30 copay	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	$50 copay	50% after deductible
Diagnostic test (x-ray, lab)	$50 copay	50% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	20% after deductible	50% after deductible
Outpatient surgery and related services	20% after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	$50 copay	50% after deductible
Chiropractic care (20-visit limit)	$30 copay	50% after deductible
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	50% after deductible
Outpatient services	$30 copay	50% after deductible
Ancillary Services		
Home health care services – 100 visits	20% after deductible	50% after deductible
Hospice services	20% after deductible	50% after deductible
Skilled nursing facility – 45 days	20% after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	20% after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$50 copay	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$50 copay	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$15/$60/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 3000 PPO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 5000 HMO

Choice Networks

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,600/$13,200	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$40 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$60 copay	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$60 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$40 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$25/$125/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 5000 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 5000 HMO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,350/$12,700	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$40 copay	Not covered
Specialist visit (including post-natal visit, allergy treatment)	$60 copay	Not covered
Diagnostic test (x-ray, lab)	$40 copay after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	$60 copay	Not covered
Chiropractic care (20-visit limit)	$30 copay	Not covered
Emergency Services		
Emergency room services	$250 copay	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	$100 copay	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	$40 copay	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$40 copay after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	$40 copay after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$25/$125/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 5000 HMO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

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HAP Personal Alliance 5000 PPO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	$10,000/$20,000
COINSURANCE		
Member	20%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$6,600/$13,200	$15,000/$30,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	$40 copay	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	$60 copay	50% after deductible
Diagnostic test (x-ray, lab)	20% after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	20% after deductible	50% after deductible
Outpatient surgery and related services	20% after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	$60 copay	50% after deductible
Chiropractic care (20-visit limit)	$30 copay	50% after deductible
Emergency Services		
Emergency room services	20% after in-network deductible	
Urgent care centers or facilities	$65 copay	
Emergency transport/ambulance	20% after in-network deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	50% after deductible
Outpatient services	$40 copay	50% after deductible
Ancillary Services		
Home health care services – 100 visits	20% after deductible	50% after deductible
Hospice services	20% after deductible	50% after deductible
Skilled nursing facility – 45 days	20% after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	20% after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
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Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	$25/$125/50%/50%	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 5000 PPO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

BRONZE

HAP Personal Alliance 5000 HMO (HSA)

Choice Networks

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,450/$12,900	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	20% after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	20% after deductible	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	20% after deductible	Not covered
Chiropractic care (20-visit limit)	20% after deductible	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	20% after deductible	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	20% after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	20% after deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

This Schedule of Benefits is designed to provide an overview of the HAP Personal Alliance 5000 HMO (HSA) Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern.

BRONZE

HAP Personal Alliance 5000 HMO (HSA)

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	Not applicable
COINSURANCE		
Member	20%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,450/$12,900	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	20% after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	20% after deductible	Not covered
Diagnostic test (x-ray, lab)	20% after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	20% after deductible	Not covered
Chemotherapy/Dialysis/Radiation	20% after deductible	Not covered
Outpatient surgery and related services	20% after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	20% after deductible	Not covered
Chiropractic care (20-visit limit)	20% after deductible	Not covered
Emergency Services		
Emergency room services	20% after deductible	
Urgent care centers or facilities	20% after deductible	
Emergency transport/ambulance	20% after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	Not covered
Outpatient services	20% after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	20% after deductible	Not covered
Hospice services	20% after deductible	Not covered
Skilled nursing facility – 45 days	20% after deductible	Not covered
Durable medical equipment/Prosthetic devices	20% after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	20% after deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

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BRONZE

HAP Personal Alliance 5000 PPO (HSA)

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Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$5,000/$10,000	$10,000/$20,000
COINSURANCE		
Member	20%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$6,450/$12,900	$15,000/$30,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	20% after deductible	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	20% after deductible	50% after deductible
Diagnostic test (x-ray, lab)	20% after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	20% after deductible	50% after deductible
Outpatient surgery and related services	20% after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	20% after deductible	50% after deductible
Chiropractic care (20-visit limit)	20% after deductible	50% after deductible
Emergency Services		
Emergency room services	20% after in-network deductible	
Urgent care centers or facilities	20% after in-network deductible	
Emergency transport/ambulance	20% after in-network deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	20% after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	20% after deductible	50% after deductible
Outpatient services	20% after deductible	50% after deductible
Ancillary Services		
Home health care services – 100 visits	20% after deductible	50% after deductible
Hospice services	20% after deductible	50% after deductible
Skilled nursing facility – 45 days	20% after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	20% after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	20% after deductible	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	20% after in-network deductible	

This product has an aggregate/umbrella deductible. This means each member on the health plan contributes to the overall family deductible. If there is only one person on the contract, the individual deductible would apply.

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CATASTROPHIC

HAP Personal Alliance 6600 HMO

Choice Networks

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$6,600/$13,200	Not applicable
COINSURANCE		
Member	0%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,600/$13,200	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Limit of 3 PCP then covered after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	Not covered
Diagnostic test (x-ray, lab)	Covered after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	Covered after deductible	Not covered
Chemotherapy/Dialysis/Radiation	Covered after deductible	Not covered
Outpatient surgery and related services	Covered after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	Not covered
Chiropractic care (20-visit limit)	Covered after deductible	Not covered
Emergency Services		
Emergency room services	Covered after deductible	
Urgent care centers or facilities	Covered after deductible	
Emergency transport/ambulance	Covered after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	Not covered
Outpatient services	Covered after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	Not covered
Hospice services	Covered after deductible	Not covered
Skilled nursing facility – 45 days	Covered after deductible	Not covered
Durable medical equipment/Prosthetic devices	Covered after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after deductible	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

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CATASTROPHIC

HAP Personal Alliance 6600 HMO

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Health Plans for Individuals and Families

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Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$6,600/$13,200	Not applicable
COINSURANCE		
Member	0%	Not applicable
OUT-OF-POCKET LIMIT		
Individual/Family	$6,600/$13,200	Not applicable
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Limit of 3 PCP then covered after deductible	Not covered
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	Not covered
Diagnostic test (x-ray, lab)	Covered after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	Covered after deductible	Not covered
Chemotherapy/Dialysis/Radiation	Covered after deductible	Not covered
Outpatient surgery and related services	Covered after deductible	Not covered
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	Not covered
Chiropractic care (20-visit limit)	Covered after deductible	Not covered
Emergency Services		
Emergency room services	Covered after deductible	
Urgent care centers or facilities	Covered after deductible	
Emergency transport/ambulance	Covered after deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	Not covered
Outpatient services	Covered after deductible	Not covered
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	Not covered
Hospice services	Covered after deductible	Not covered
Skilled nursing facility – 45 days	Covered after deductible	Not covered
Durable medical equipment/Prosthetic devices	Covered after deductible	Not covered
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	Not covered
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	Not covered	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after deductible	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

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CATASTROPHIC

HAP Personal Alliance 6600 PPO

Personal Alliance®

Health Plans for Individuals and Families

chooseHAP.org

Schedule of Benefits

Benefit Period: Calendar Year	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual/Family	$6,600/$13,200	$10,000/$20,000
COINSURANCE		
Member	0%	50%
OUT-OF-POCKET LIMIT		
Individual/Family	$6,600/$13,200	$15,000/$30,000
Preventive Care		
Periodic physical exams, well baby/child exams, routine eye and hearing exams and prenatal visits	Covered	Not covered
Immunizations, related lab tests and x-rays, pap smears and mammograms	Covered	Not covered
Outpatient Services		
PCP visit to treat an injury/illness	Limit of 3 PCP then covered after deductible	50% after deductible
Specialist visit (including post-natal visit, allergy treatment)	Covered after deductible	50% after deductible
Diagnostic test (x-ray, lab)	Covered after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	Covered after deductible	50% after deductible
Chemotherapy/Dialysis/Radiation	Covered after deductible	50% after deductible
Outpatient surgery and related services	Covered after deductible	50% after deductible
Eye exams/Audiology exams (for medical reasons)	Covered after deductible	50% after deductible
Chiropractic care (20-visit limit)	Covered after deductible	50% after deductible
Emergency Services		
Emergency room services	Covered after in-network deductible	
Urgent care centers or facilities	Covered after in-network deductible	
Emergency transport/ambulance	Covered after in-network deductible	
Inpatient Services		
Inpatient hospital, labor and delivery, and related services (Intensive, cardiac and other specialty care units as medically necessary)	Covered after deductible	50% after deductible
Mental Health, Behavioral Health and Substance Abuse Needs		
Inpatient services	Covered after deductible	50% after deductible
Outpatient services	Covered after deductible	50% after deductible
Ancillary Services		
Home health care services – 100 visits	Covered after deductible	50% after deductible
Hospice services	Covered after deductible	50% after deductible
Skilled nursing facility – 45 days	Covered after deductible	50% after deductible
Durable medical equipment/Prosthetic devices	Covered after deductible	50% after deductible
Rehabilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	50% after deductible
Habilitative services 30 visits for physical therapy/occupational therapy 30 visits for speech therapy	Covered after deductible	50% after deductible
Other Services		
Pediatric/Adult dental	On Marketplace - Not covered/Off Marketplace - optional benefits available	
Pediatric vision hardware	One pair of glasses every calendar year	
Adult vision hardware	One pair of glasses every calendar year	
Prescription Drugs		
Rx copay generic/preferred brand/non-preferred brand/specialty	Covered after in-network deductible	

This product has an embedded deductible. This means each family member has a separate deductible. Once one family member has met his/her deductible, the member will begin receiving benefits even though the total family deductible has not been met.

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2015 Delta Dental Pediatric Benefits

Personal Alliance®
Health Plans for Individuals and Families

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Pediatric dental is an EHB and is required for all members under the age of 19, with a health plan purchased directly through HAP. For the pediatric-only dental plans, a child's coverage will terminate at the end of the year he/she turns 19. If the group has also elected adult dental coverage, than the child's benefit will automatically convert to the adult plan and associated premium on January 1 of the year following his/her 19th birthday.

DELTA DENTAL®

Schedule of Benefits

	IN-NETWORK		OUT-OF-NETWORK
	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
Diagnostic and Preventive	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic and Preventive Services exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush Biopsy – to detect oral cancer	100%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Radiographs – x-rays	100%	80%	80%
Sealants – to prevent decay of permanent teeth	100%	80%	80%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Relines and Repairs – to bridges and dentures	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Major Services			
Prosthodontic Services – bridges and dentures	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Maximum Payment and Deductible			
Out-of-pocket maximum	$350 per eligible member/$700 per family		
Deductible (does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, Brush Biopsy or sealants)	$25 per eligible member		

In-network out-of-pocket maximum for EHB covered services—An out-of-pocket maximum is the maximum amount that you or an eligible dependent will pay for covered services throughout a benefit year. For all in-network EHB covered services provided to individuals under the age of 19, your maximum out-of-pocket payments under this policy shall be $350 per benefit year if this policy covers one individual under the age of 19, or $700 per benefit year if this policy covers two or more individuals under the age of 19. Any coinsurance, copayments or deductibles paid by you for in-network EHB covered services provided to individuals under the age of 19 shall count toward that in-network out-of-pocket maximum. The in-network out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) payments made by you for non-covered services; (iii) payments made by you to out-of-network dentists; (iv) coinsurance, copayments or deductibles paid by you for services other than EHB covered services; or (v) coinsurance, copayments or deductibles paid by you for EHB covered services provided to individuals 19 years of age and older.

Once your applicable in-network out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to individuals under the age of 19 will be covered at 100 percent of Delta Dental's Maximum Approved Fee.

Out-of-network out-of-pocket maximum for EHB covered services—There is no annual out-of-pocket maximum for out-of-network EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balanced billing amounts associated with all out-of-network EHB covered services provided to you or your eligible dependent throughout the benefit year.

Annual and lifetime maximum payments for EHB covered services—For all EHB covered services provided to individuals under the age of 19, there are no annual or lifetime maximum payments.

Deductibles for EHB covered services—$25 deductible per individual per benefit year. The deductible does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, Brush Biopsy or sealants.

Waiting period for EHB covered services—There are no waiting periods for individuals under the age of 19 seeking EHB covered services.

This document is intended as a supplement to your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to your certificate and summary for costs and complete details of coverage, including policy exclusions and limitations, or call us at the number listed on the front of this brochure.

This policy is underwritten by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation.

2015 Delta Dental PPO Adult Benefits

Personal Alliance®
Health Plans for Individuals and Families

chooseHAP.org

For families that want adult dental coverage, all adults have to elect coverage. Adults without children will be charged a $0 pediatric plan premium and will be provided with evidence of compliance for the EHB pediatric coverage from Delta Dental. All adults (over the age of 19 upon effective date) will be included if adult coverage is selected. Only the three oldest children under 19 are charged the pediatric rate. If a group indicates they have EHB-certified pediatric coverage, HAP will not offer adult-only coverage.

DELTA DENTAL®

Schedule of Benefits

	IN-NETWORK		OUT-OF-NETWORK
	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
Diagnostic and Preventive	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic and Preventive Services exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush Biopsy – to detect oral cancer	100%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Radiographs – x-rays	100%	80%	80%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Relines and Repairs – to bridges and dentures	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Major Services			
Prosthodontic Services – bridges and dentures	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Maximum Payment and Deductible			
Maximum payment per benefit year	$1,000 per individual per benefit year		
Deductible (does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, Brush Biopsy or sealants)	$25 per eligible member		

Annual and lifetime maximum payments for non-EHB covered services—For individuals 19 years of age or older, or individuals under the age of 19 seeking non-EHB covered services, the maximum payment is $1,000 per individual total per benefit year on all services.

Out-of-pocket maximum payment for non-EHB covered services—An out-of-pocket maximum is the maximum amount that you or your eligible dependent will pay for covered services throughout a benefit year. There is no annual out-of-pocket maximum payment for non-EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balanced billing amounts associated with all non-EHB covered services provided to you or your eligible dependent throughout the benefit year.

Deductibles for non-EHB covered services—$25 deductible per individual per benefit year. The deductible does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment or Brush Biopsy.

Waiting period for non-EHB covered services—There are no waiting periods for covered services under this plan.

Eligibility—In addition to you, the following persons are eligible under this policy: your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for federal income tax purposes and/or who are not permanently disabled.

You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated prior to completing 12 months, you may not re-enroll for at least 12 months from the date of termination.

Benefits will cease on the last day of the month in which you have paid premium.

This document is intended as a supplement to your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to your certificate and summary for costs and complete details of coverage, including policy exclusions and limitations, or call us at the number listed on the front of this brochure.

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