Flexible coverage for individuals and families.

Your guide to understanding and selecting your individual health plan.

Table of Contents

SOLO is a product of Alliance Health and Life Insurance Company, Inc, a wholly owned subsidiary of Health Alliance Plan.

Everything you've ever wanted in a health plan—and so much more.

Not covered by a group health plan? Go SOLO! Our plans are perfect for individuals and families—especially if you're between jobs, a recent college graduate, self-employed or an early retiree.

- **Take your pick!** SOLO offers a choice of Preferred Provider Organization (PPO) plans with both in-network and out-of-network benefits. Plus, you can pair your plan with a Health Savings Account (HSA) that you control where your dollars go and when they stay in your pocket.
- **Priced just right!** SOLO provides Michigan residents with affordable health insurance coverage from Michigan's most experienced health plan. You can even choose your deductibles, coinsurance and out-of-pocket maximums.
- **Comes with extras!** SOLO offers special discounts on services such as LASIK and Weight Watchers®.
- **Doesn't get any easier!** It can take less than 30 minutes to apply and coverage can begin as soon as the first day of the month following acceptance.

When you go SOLO, you're never alone.

SOLO is all about your health—and your options, like access to over 18,000 doctors, and leading area hospitals. When you choose SOLO from HAP, you also get personalized wellness programs, preventive care and award-winning customer service.

And, with any of the SOLO plans from HAP, you get worldwide urgent care and emergency coverage, no matter where you travel.

SOLO is big on little extras.

You'll get extra perks when going SOLO. Thanks to the HAP Advantage* program, you'll receive money-saving discounts and have access to a variety of health and wellness-related activities, entertainment and Web sites, many which are local to southeast Michigan. They include:

- **Weight Watchers®**—As part of HAP's commitment to healthy living and preventive medicine, qualified members can join Weight Watchers® for just $25 and HAP will pay the rest of the enrollment fee. That's a great savings passed on to you!
- **FitZone for Women**—Save 60% off registration and $5 off monthly dues at our Livonia (734-525-4636), Grand Blanc (810-953-3870) and Waterford (734-525-4636) locations. Call for more information.
- **Chiropractors**—Save 15% on non-covered chiropractic services from participating chiropractors.
- **YMCAs of Metro Detroit**—No sign-up fee at the eleven Metro Detroit YMCAs—a savings of up to $250 for HAP members.
- **Henry Ford LASIK**—Save $562 on LASIK services (both eyes).

Get even more with your SOLO coverage—another way HAP is working to improve health and enhance lives.

- **Home delivery pharmacy**—In addition to filling your prescriptions at a retail pharmacy, we offer mail order prescription service through Pharmacy Advantage Home Delivery. You get a 90-day supply of your medication, saving you time and money by eliminating monthly trips to the pharmacy. To learn more, visit **http://www.hap.org/formulary/mo_prescriptions.php**.
- ***iStrive℠ for better health***—HAP has partnered with HealthMedia® to offer this revolutionary, digital health coaching program, exclusively for members. ***iStrive℠*** programs offer a free, confidential, health risk assessment and a suite of additional programs to help you learn how to live a healthier life. For more information, log on at **hap.org** and go to ***iStrive℠***.

Your SOLO health plans come with award-winning customer service

HAP's Client Service Specialists provide fast, accurate and courteous service to members. And HAP is ranked among the top 10 percent of health plans across the country for customer satisfaction. Plus during your first two years as a HAP SOLO member, we provide you with an assigned personal service coordinator to answer your questions and provide information and services.

* The HAP Advantage program is a value-added program and the services and products made available under this program are not covered benefits under the Health Alliance Plan (HAP) Subscriber Contract, Riders or Member Handbook or otherwise payable by HAP. HAP, its affiliates, agents and assigns make no representations or warranties regarding the quality, price or effectiveness of the services or products, or the credentialing of the providers, made available by HAP Advantage.

Online tools make membership easy.

Not only is it easy to enroll with SOLO online, but you can manage your coverage online too! Simply register at **hap.org** for access to convenient, personalized and secure online tools, including:

- Benefits and Coverage Information
- View a Doctor
- Claims
- Pharmacy Claims
- Copays—information on emergency, urgent care, physicians office or pharmacy copays
- Request a new ID card
- Prescription Search
- Health Reminders
- *iStrive*[SM]

Get started with SOLO

SOLO health plans are perfect for individuals and families, no matter what your situation or budget. With SOLO you have your choice of plans, access to leading area doctors and hospitals and all kinds of extras. For help selecting the health plan that's right for you, check out the plan options beginning on Page 4.

Just check out the choices. And you'll know what we mean when we say SOLO has flexible coverage for individuals and families.

Selecting the right health plan

You visit the doctor but want to keep out-of-pocket costs low:

SOLO PPO 500	$$$

You'd like to keep a balance between coverage and cost:

SOLO PPO 1000—Rx	$$
SOLO PPO 1000—no Rx	$
SOLO PPO 1200	$$

You're looking for low monthly premiums:

SOLO PPO 2500	$
SOLO PPO 3000—Rx	$$
SOLO PPO 3000—No Rx	$
SOLO PPO 5000	$

You want a plan that works with an HSA:

SOLO PPO HSA 2500	$$
SOLO PPO HSA 5000	$$

Need more help choosing? Check our the Plan Summary on Page 5 to compare all of our SOLO health plans, or get the details of each plan on Pages 9-14. You also have the option to add dental benefits.

SOLO Plan	Sample Costs for 40 Year Old Male*	Sample Costs for 36 Year Old Female*
SOLO PPO 5000	$	$
SOLO 3000/No Rx	$	$$
SOLO 1000/No Rx	$	$$
SOLO PPO 2500	$	$$
SOLO HSA PPO 2500	$$	$$
SOLO 3000/Rx	$$	$$
SOLO HSA PPO 5000	$$	$$
SOLO 1000/Rx	$$	$$$
SOLO PPO 1200	$$	$$$
SOLO PPO 500	$$$	$$$

Legend	
$	$0-149
$$	$150-199
$$$	$200+

*The above dollar figures are not actual costs and are only a representation of the plan costs for SOLO members based on gender.

Health Plan Summary At A Glance

Regardless of your situation, needs, or budget – HAP has a health plan that's right for you.

Plan	Deductible Individual	Deductible Family	Coinsurance	Out-of-pocket Maximum Individual	Out-of-pocket Maximum Family
With Rx					
PPO 500 In-Network	$500	$1,000	70%	$3,000	$6,000
PPO 500 Out-of-Network	$1,000	$2,000	50%	$6,000	$12,000
PPO 1200 In-Network	$1,200	$2,400	70%	$5,200	$10,400
PPO 1200 Out-of-Network	$2,400	$4,800	50%	$10,400	$20,800
1000 Rx In-Network	$1,000	$2,000	70%	$5,000	$10,000
1000 Rx Out-of-Network	$2,000	$4,000	50%	$10,000	$20,000
PPO 2500 In-Network	$2,500	$5,000	80%	$6,500	$13,000
PPO 2500 Out-of-Network	$5,000	$10,000	50%	$13,000	$26,000
PPO 5000 In-Network	$5,000	$10,000	80%	$10,000	$20,000
PPO 5000 Out-of-Network	$10,000	$20,000	50%	$20,000	$40,000
3000 Rx In-Network	$3,000 (combined)	—	100%	$3,000	—
3000 Rx Out-of-Network		—	50%	$10,000	—
Without Rx					
1000 No Rx In-Network	$1,000	$2,000	70%	$5,000	$10,000
1000 No Rx Out-of-Network	$2,000	$4,000	50%	$10,000	$20,000
3000 No Rx In-Network	$3,000 (combined)	—	100%	$3,000	—
3000 No Rx Out-of-Network		—	50%	$10,000	—
HSA Plans					
PPO HSA 2500 In-Network	$2,500	$5,000	80%	$5,000	$10,000
PPO HSA 2500 Out-of-Network	$5,000	$10,000	50%	$10,000	$20,000
PPO HSA 5000 In-Network	$5,000	$10,000	100%	$5,000	$10,000
PPO HSA 5000 Out-of-Network	$10,000	$20,000	50%	$20,000	$40,000

Health Savings Account (HSA) Plans

HSA defined.

A HSA is a savings account similar to a traditional Individual Retirement Account (IRA), but designated for medical expenses. With an HSA, you can pay for current covered health care expenses and save for future qualified medical health care expenses. Plus your contributions may be tax deductible.

To be eligible to set up an HSA and make annual contributions, you must be covered by a qualified High-Deductible Health Plan (HDHP).

A HDHP is a health insurance plan with minimum annual deductions for 2011 of $1,200 for individuals or $2,400 for family coverage. The annual out-of-pocket expense maximums (including deductibles, coinsurance and copayments but not including premiums) cannot exceed $5,950 for individuals or $11,900 for families. The deductible and maximum out-of-pocket expenses for 2011 are adjusted annually for inflation.

How an HSA works.

You can use your HSA to pay for your health care costs, from doctor and hospital visits to copayments, eyeglasses and prescriptions. Covered health care costs paid from your HSA are applied toward meeting your annual health plan deductible. If your combined expenses, whether small expenses, routine costs or a serious injury or accident, exceed your health plan deductible, an out-of-pocket maximum "caps" your costs but leaves your coverage in place.

HSA benefits.

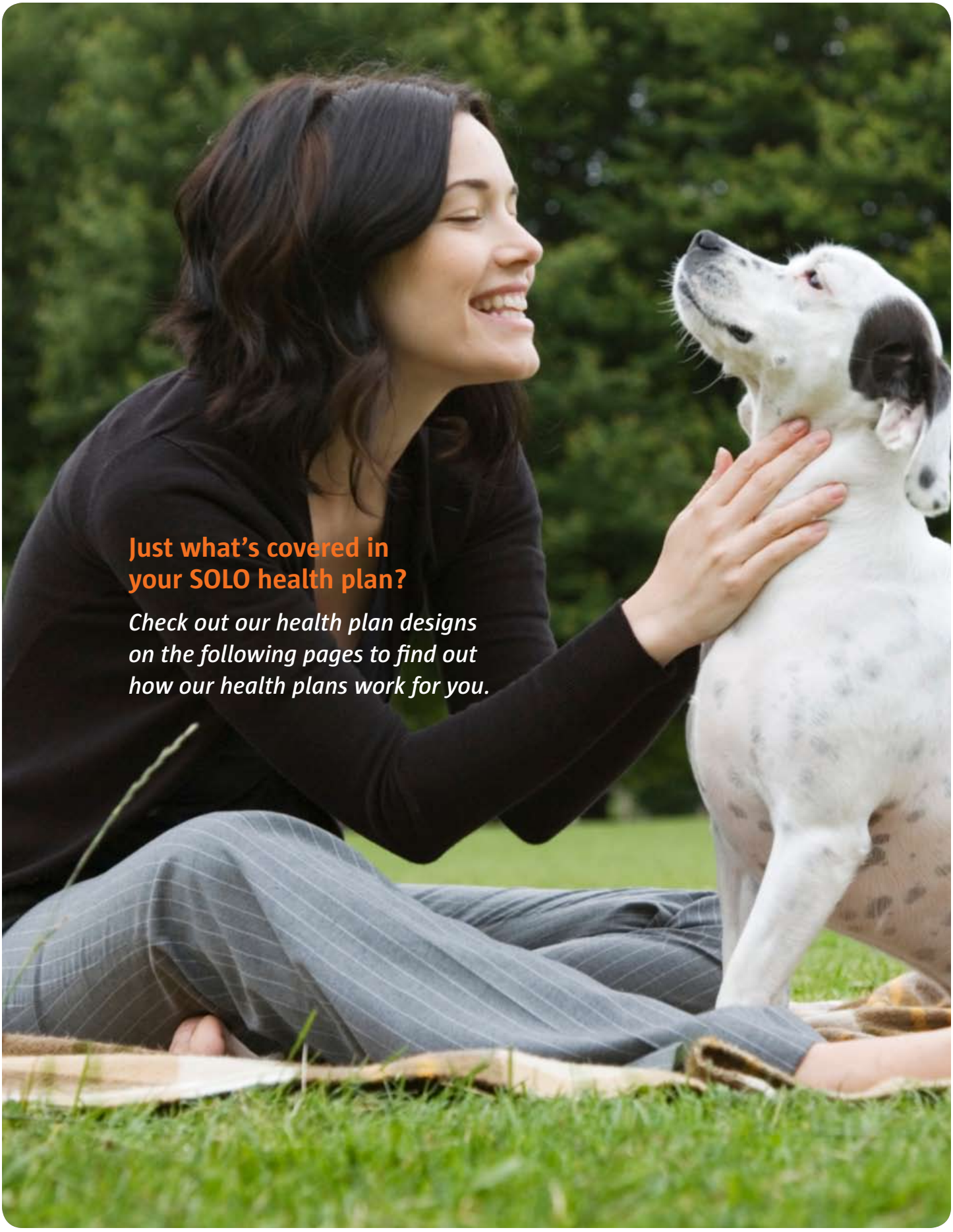
Tax-advantaged

- Contributions are made with pre-tax dollars; they're not subject to federal or state income taxes in Michigan, so you pay less income tax at the end of the year.
- The interest you earn on your HSA balance isn't taxed.
- Withdrawals from your HSA for qualified medical expenses aren't subject to federal or state income tax in Michigan.

Flexible

- The money grows and remains with you, even when you change medical plans, or retire—and even if you're no longer eligible to make contributions. After age 65, or in cases of disability, the funds in the account can be used for non-qualified expenses.
- As long as you're covered by a qualified HDHP, you, your employer, family members or anyone else may contribute to your HSA up to the maximum annual contribution limit.

HAP's preferred HSA partner is the ACS/BNY Mellon HSA Solution®. To learn more, check out the ACS/BNY Mellon Web site at www.hsamember.com.



These Summaries of Benefits are designed to provide an overview of the SOLO PPO Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this summary and the policy, the terms and conditions of the policy govern. SOLO PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the Out-of-Network benefit level.

Preferred Provider Organization (PPO) Summary Of Benefits

Plan Designs: PPO 500 & PPO 1200					
	PPO 500		PPO 1200		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible Individual	$500	$1,000	$1,200	$2,400	
Deductible Family	$1,000	$2,000	$2,400	$4,800	
Coinsurance	70%	50%	70%	50%	
Out-of-pocket Maximum Individual	$3,000	$6,000	$5,200	$10,400	
Out-of-pocket Maximum Family	$6,000	$12,000	$10,400	$20,800	
Health Care Services					**Limitations**
Preventive Services Preventive Office Visits Periodic Physical Exams Well Baby / Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	Covered	Not covered	Covered	Not covered	
Outpatient & Physician Services Office Visits / Allergy Testing and Injections Other Injections / Lab Tests & X-Rays Back Care 1 Outpatient / Office Surgery & Related Svc Radiation / Chemotherapy Eye Examinations (for medical reasons) 2 Audiology Examinations 3	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year. 2 Does not include lenses/frames/contacts. 3 Does not include hearing aids.
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 4	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must meet emergency guidelines. 4 Emergency transport only.
Inpatient Hospital Services Semi-Private Room Intensive, Cardiac and Other Specialty Care units as medically necessary Related Therapy Services Surgery and Related Services Related Lab Tests and X-Rays Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services* Home Health Care 5 Hospice Care 6 Physical Therapy, Speech Therapy, Occupational Therapy 7 Durable Medical Equipment (DME) 8 Prosthetics and Orthotics 9 Skilled Nursing Facility 10	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	*Limitations are a combination of in and out-of-network services. 5 100 visits per calendar year. 6 210 days lifetime. 7 60 visits combined. 8 Must be an authorized piece of equipment based on Alliance guidelines. 9 Must be an authorized piece of equipment based on Alliance guidelines. 10 100 days per calendar year.
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755; Limited to 5 days per person per calendar year.
Mental Health Services Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per calendar year.
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Residential services limited to 10 days per person per calendar year. Outpatient services limited to 5 visits per person per calendar year.
Prescription Drugs	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Oral Contraceptives and devices included.
Maternity Services	Not Covered	Not Covered	Not Covered	Not Covered	
Dental	Not Covered***	Not Covered***	Not Covered***	Not Covered***	***Optional rider available. See Page 14.

Preferred Provider Organization (PPO) Summary Of Benefits

Plan Designs: PPO 2500 & PPO 5000					
	PPO 2500		PPO 5000		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible Individual	$2,500	$5,000	$5,000	$10,000	
Deductible Family	$5,000	$10,000	$10,000	$20,000	
Coinsurance	80%	50%	80%	50%	
Out-of-pocket Maximum Individual	$6,500	$13,000	$10,000	$20,000	
Out-of-pocket Maximum Family	$13,000	$26,000	$20,000	$40,000	
Health Care Services					**Limitations**
Preventive Services Preventive Office Visits Periodic Physical Exams Well Baby / Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	Covered	Not covered	Covered	Not covered	
Outpatient & Physician Services Office Visits / Allergy Testing and Injections Other Injections / Lab Tests & X-Rays Back Care 1 Outpatient / Office Surgery & Related Svc Radiation / Chemotherapy Eye Examinations (for medical reasons) 2 Audiology Examinations 3	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year. 2 Does not include lenses/frames/contacts. 3 Does not include hearing aids.
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 4	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must meet emergency guidelines. 4 Emergency transport only.
Inpatient Hospital Services Semi-Private Room Intensive, Cardiac and Other Specialty Care units as medically necessary Related Therapy Services Surgery and Related Services Related Lab Tests and X-Rays Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services* Home Health Care 5 Hospice Care 6 Physical Therapy, Speech Therapy, Occupational Therapy 7 Durable Medical Equipment (DME) 8 Prosthetics and Orthotics 9 Skilled Nursing Facility 10	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	*Limitations are a combination of in and out-of-network services. 5 100 visits per calendar year. 6 210 days lifetime. 7 60 visits combined. 8 Must be an authorized piece of equipment based on Alliance guidelines. 9 Must be an authorized piece of equipment based on Alliance guidelines. 10 100 days per calendar year.
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755; Limited to 5 days per person per calendar year.
Mental Health Services Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per calendar year.
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Residential services limited to 10 days per person per calendar year. Outpatient services limited to 5 visits per person per calendar year.
Prescription Drugs	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Generic $15 Preferred $30 Non-Preferred $50	Oral Contraceptives and devices included.
Maternity Services	Not Covered	Not Covered	Not Covered	Not Covered	
Dental	Not Covered***	Not Covered***	Not Covered***	Not Covered***	***Optional rider available. See Page 14.

Health Savings Account — Preferred Provider Organization (HSA PPO) Summary Of Benefits

Plan Designs: PPO HSA 2500 & PPO HSA 5000					
	PPO HSA 2500		PPO HSA 5000		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible Individual	$2,500	$5,000	$5,000	$10,000	
Deductible Family	$5,000	$10,000	$10,000	$20,000	
Coinsurance	80%	50%	100%	50%	
Out-of-pocket Maximum Individual	$5,000	$10,000	$5,000	$20,000	
Out-of-pocket Maximum Family	$10,000	$20,000	$10,000	$40,000	
Health Care Services					**Limitations**
Preventive Services Preventive Office Visits Periodic Physical Exams Well Baby / Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	Covered	Not covered	Covered	Not covered	
Outpatient & Physician Services Office Visits / Allergy Testing and Injections Other Injections / Lab Tests & X-Rays Back Care 1 Outpatient / Office Surgery & Related Svc Radiation / Chemotherapy Eye Examinations (for medical reasons) 2 Audiology Examinations 3	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year. 2 Does not include lenses/frames/contacts. 3 Does not include hearing aids.
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 4	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must meet emergency guidelines. 4 Emergency transport only.
Inpatient Hospital Services Semi-Private Room Intensive, Cardiac and Other Specialty Care units as medically necessary Related Therapy Services Surgery and Related Services Related Lab Tests and X-Rays Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services* Home Health Care 5 Hospice Care 6 Physical Therapy, Speech Therapy, Occupational Therapy 7 Durable Medical Equipment (DME) 8 Prosthetics and Orthotics 9 Skilled Nursing Facility 10	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	*Limitations are a combination of in and out-of-network services. 5 100 visits per calendar year. 6 210 days lifetime. 7 60 visits combined. 8 Must be an authorized piece of equipment based on Alliance guidelines. 9 Must be an authorized piece of equipment based on Alliance guidelines. 10 100 days per calendar year.
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755; Limited to 5 days per person per calendar year.
Mental Health Services Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per calendar year.
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Residential services limited to 10 days per person per calendar year. Outpatient services limited to 5 visits per person per calendar year.
Prescription Drugs	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Oral Contraceptives and devices included.
Maternity Services	Not Covered	Not Covered	Not Covered	Not Covered	
Dental	Not Covered***	Not Covered***	Not Covered***	Not Covered***	***Optional rider available. See Page 14.

Preferred Provider Organization (PPO) Summary Of Benefits

Plan Designs: 1000 Rx & 1000 No Rx					
	1000 Rx		1000 No Rx		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible Individual	$1,000	$2,000	$1,000	$2,000	
Deductible Family	$2,000	$4,000	$2,000	$4,000	
Coinsurance	70%	50%	70%	50%	
Out-of-pocket Maximum Individual	$5,000	$10,000	$5,000	$10,000	
Out-of-pocket Maximum Family	$10,000	$20,000	$10,000	$20,000	
Health Care Services					**Limitations**
Preventive Services Preventive Office Visits Periodic Physical Exams Well Baby / Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	Covered	Not covered	Covered	Not covered	
Outpatient & Physician Services Office Visits / Allergy Testing and Injections Other Injections / Lab Tests & X-Rays Back Care 1 Outpatient / Office Surgery & Related Svc Radiation / Chemotherapy Eye Examinations (for medical reasons) 2 Audiology Examinations 3	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year. 2 Does not include lenses/frames/contacts. 3 Does not include hearing aids.
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 4	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must meet emergency guidelines. 4 Emergency transport only.
Inpatient Hospital Services Semi-Private Room Intensive, Cardiac and Other Specialty Care units as medically necessary Related Therapy Services Surgery and Related Services Related Lab Tests and X-Rays Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services* Home Health Care 5 Hospice Care 6 Physical Therapy, Speech Therapy, Occupational Therapy 7 Durable Medical Equipment (DME) 8 Prosthetics and Orthotics 9 Skilled Nursing Facility 10	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	*Limitations are a combination of in and out-of-network services. 5 100 visits per calendar year. 6 210 days lifetime. 7 60 visits combined. 8 Must be an authorized piece of equipment based on Alliance guidelines. 9 Must be an authorized piece of equipment based on Alliance guidelines. 10 100 days per calendar year.
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755; Limited to 5 days per person per calendar year.
Mental Health Services Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per calendar year.
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Residential services limited to 10 days per person per calendar year. Outpatient services limited to 5 visits per person per calendar year.
Prescription Drugs	$500 per person per calendar year deductible, then member pays copay Generic $15 Preferred $30 Non-Preferred $50		Prescriptions Not Covered		Oral Contraceptives and devices included if prescriptions are covered.
Maternity Services	Not Covered	Not Covered	Not Covered	Not Covered	
Dental	Not Covered***	Not Covered***	Not Covered***	Not Covered***	***Optional rider available. See Page 14.

Preferred Provider Organization (PPO) Summary Of Benefits

Plan Designs: 3000 Rx & 3000 No Rx					
	3000 Rx		3000 No Rx		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible Individual	$3,000 (combined)		$3,000 (combined)		
Coinsurance	100%	50%	100%	50%	
Out-of-pocket Maximum Individual	$3,000	$10,000	$3,000	$10,000	
Health Care Services					**Limitations**
Preventive Services Preventive Office Visits Periodic Physical Exams Well Baby / Child Exams Immunizations Routine Eye and Hearing Exams Related Lab Tests and X-Rays Pap Smears and Mammograms	Covered	Not covered	Covered	Not covered	Preventive & Outpatient office visits limited to 4 per person per calendar year. 4 office visits are not subject to deductible. Copays are not applied to the out-of-pocket maximum. Routine Eye Exam limited to one per year.
Outpatient & Physician Services Office Visits / Allergy Testing and Injections Other Injections / Lab Tests & X-Rays Back Care 1 Outpatient / Office Surgery & Related Svc Radiation / Chemotherapy Eye Examinations (for medical reasons) 2 Audiology Examinations 3	$25 copay per office visit $20 copay/Back Care/Chiropractic Care visit $25 copay on diagnostic lab/xray and other hospital outpatient services $100 copay/ Outpatient Surgery	50% coinsurance 20% coinsurance/ Back Care/ Chiropractic Care visit 50% coinsurance on diagnostic lab/xray and other hospital outpatient services 50% coinsurance/ Outpatient Surgery	$25 copay per office visit $20 copay/Back Care/Chiropractic Care visit $25 copay on diagnostic lab/xray and other hospital outpatient services $100 copay/ Outpatient Surgery	50% coinsurance 20% coinsurance/ Back Care/ Chiropractic Care visit 50% coinsurance on diagnostic lab/xray and other hospital outpatient services 50% coinsurance/ Outpatient Surgery	Preventive & Outpatient office visits limited to 4 per person per calendar year. 4 office visits are not subject to deductible. 1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year. 2 Does not include lenses/frames/contacts. Copays are not applied to the out-of-pocket maximum services (other than office visits) in this category are subject to deductible. 3 Does not include hearing aids.
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 4	$100 copay/ER visit $50 copay/ Urgent Care visit	$100 copay/ER visit $50 copay/ Urgent Care visit 50% coinsurance on Ambulance services	$100 copay/ER visit $50 copay/ Urgent Care visit	$100 copay/ER visit $50 copay/ Urgent Care visit 50% coinsurance on Ambulance services	Must meet emergency guidelines. ER Copay waived if admitted. Copay will not be applied to deductible or out-of-pocket maximum. 4 Emergency transport only.
Inpatient Hospital Services Semi-Private Room Intensive, Cardiac and Other Specialty Care units as medically necessary Related Therapy Services Surgery and Related Services Related Lab Tests and X-Rays Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Inpatient services limited to 20 days (combined in-and out-of-network) per person per calendar year.
Ancillary Services* Home Health Care 5 Hospice Care 6 Physical Therapy, Speech Therapy, Occupational Therapy 7 Durable Medical Equipment (DME) 8 Prosthetics and Orthotics 9 Skilled Nursing Facility 10	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	*Limitations are a combination of in and out-of-network services. 5 30 visits per calendar year. 6 210 days lifetime. 7 30 visits combined. 8 Must be an authorized piece of equipment based on Alliance guidelines. 9 Must be an authorized piece of equipment based on Alliance guidelines. 10 100 days per calendar year.
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755; Limited to 5 days per person per calendar year.
Mental Health Services Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per calendar year.
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Residential services limited to 10 days per person per calendar year. Outpatient services limited to 5 visits per person per calendar year.
Prescription Drugs	Generic $15 copay Preferred $30 copay Non-Preferred $50 copay		Prescriptions Not Covered		Oral Contraceptives and devices included if prescriptions are covered.
Maternity Services	Not Covered	Not Covered	Not Covered	Not Covered	
Dental	Not Covered***	Not Covered***	Not Covered***	Not Covered***	***Optional rider available. See Page 14.

Optional Dental Coverage

DELTA DENTAL®

A Healthy Mouth Is Necessary To Maintaining A Healthy Body.

HAP SOLO can help you with individual dental coverage through Delta Dental.

When making decisions about your health care, don't forget about your smile. Unfortunately, dental care can be overlooked until it's too late. Minor oral health problems left untreated can lead to major problems—which can be devastating for your overall health and expensive. A quality individual dental plan from Delta Dental Plan of Michigan, Inc. can help you make sure you get the care you need to stay healthy.

Did you know?

- During a dental checkup, your dentist can detect oral cancer in its earliest stages or even when cells in your mouth are precancerous.
- Routine teeth cleanings can help diabetics keep their disease in check.
- More than 51 million school hours are lost each year to dental-related illness.[1]
- Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.[2]

Great networks

Delta Dental has the largest network of dentists in the United States. Nationwide, more than 72,000 dentists participate in Delta Dental PPO, and more than 132,000 dentists participate in Delta Dental Premier®.[3] Find a dentist

Great coverage

You can choose from three plans that cover a wide range of services you may need—from routine services like oral exams, cleanings, and X-rays to more complex (and expensive) services like bridges, crowns, and dentures.

The chart below highlights the three Delta Dental plan options as well as where to find detailed information on each plan including frequently asked questions.

HIGH PLAN	MEDIUM PLAN	LOW PLAN
Benefit Feature Sheet - Page 14	Benefit Feature Sheet - Page 15	Benefit Feature Sheet - Page 16
Delta Dental PPO (Point-of-Service) FAQ - Page 17	Delta Dental PPO (Point-of-Service) FAQ - Page 17	Delta Dental PPO (Standard) FAQ - Page 19

Call Delta Dental toll-free for more information

Learn more about Delta Dental's benefits by talking with a Delta Dental representative at (800) 971-4108. You also may access Delta Dental's interactive voice recording system at the same number.

Oral health and wellness information

Watch oral health videos on Delta Dental of Michigan's YouTube channel at http://www.youtube.com/user/DeltaDentalMichigan.

For more oral health information, please visit the Health and Wellness section of Delta Dental of Michigan's Web site at www.deltadentalmi.com.

1, 2 Oral Health in America: A Report of the Surgeon General, 2000.
3 Statistics: Delta Dental Plans Association, September 2009.

Optional Dental Coverage

DELTA DENTAL®

Benefit Features For Optional Dental Benefits—High Plan

Delta Dental PPO℠ is a point-of-service preferred provider organization program administered by Delta Dental of Michigan. You can go to any licensed dentist, but your coverage levels will be higher for some services and you may have lower out-of-pocket costs if you choose a dentist who participates in the Delta Dental PPO network. If you do not go to a Delta Dental PPO dentist, you can still save money if you choose a dentist who participates in Delta Dental Premier®, Delta Dental's managed fee-for-service plan. If you choose a dentist who doesn't participate in either plan, you are responsible for any difference between Delta Dental's fee and the amount charged by the dentist.

Delta Dental PPO (Point-of-Service)			
	Plan Pays*		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
CLASS I			
Diagnostic and Preventive Services—Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments)	100%	100%	100%
Emergency Palliative Treatment—Used to temporarily relieve pain	100%	100%	100%
Radiographs—X-rays	100%	100%	100%
CLASS II			
Oral Surgery—Extractions and dental surgery, including preoperative and postoperative care	50%	50%	50%
Minor Restorative Services—Used to repair teeth damaged by disease or injury (for example, fillings)	50%	50%	50%
Periodontics—Used to treat diseases of the gums and supporting structures of the teeth	50%	50%	50%
Endodontics—Used to treat teeth with diseased or damaged nerves (for example, root canals)	50%	50%	50%
CLASS III			
Major Restorative Services—Used when teeth cannot be restored with another filling material (for example, crowns)	50%	50%	50%
Prosthodontics—Used to replace missing natural teeth (for example, bridges, endosteal implants, and dentures)	50%	50%	50%
Maximum Payment—The per person total per calendar year for Class I, Class II and Class III Benefits is:	$1,500	$1,000	$1,000
Deductible—$50 per person total per calendar year on Class II and Class III Benefits. The deductible does not apply to Class I Benefits.			

* Coverage levels are based on the following: Delta Dental PPO—based on dentist's submitted fee or the amount in the local Delta Dental's PPO dentist fee schedule, whichever is less; Delta Dental Premier®—based on dentist's submitted fee or the maximum approved fee for Delta Dental's Premier dentist fee schedule, whichever is less; and Non-participating—based on dentist's submitted fee or Delta Dental's non-participating dentist fee, whichever is less.

Delta Dental Plan of Michigan, Inc. • P.O. Box 30416, Lansing, MI 48909
Customer Service (800) 971-4108 • www.deltadentalmi.com

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 (800) 971-4108.

Underwritten by Renaissance Life & Health Insurance Company of America. This product is available to Michigan residents only.

DELTA DENTAL®

Benefit Features For Optional Dental Benefits—Medium Plan

Delta Dental PPO℠ is a point-of-service preferred provider organization program administered by Delta Dental of Michigan. You can go to any licensed dentist, but your coverage levels will be higher for some services and you may have lower out-of-pocket costs if you choose a dentist who participates in the Delta Dental PPO network. If you do not go to a Delta Dental PPO dentist, you can still save money if you choose a dentist who participates in Delta Dental Premier®, Delta Dental's managed fee-for-service plan. If you choose a dentist who doesn't participate in either plan, you are responsible for any difference between Delta Dental's fee and the amount charged by the dentist.

Delta Dental PPO (Point-of-Service)			
	Plan Pays*		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
CLASS I			
Diagnostic and Preventive Services—Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments)	100%	50%	50%
Emergency Palliative Treatment—Used to temporarily relieve pain	100%	50%	50%
Radiographs—X-rays	100%	50%	50%
CLASS II			
Oral Surgery—Extractions and dental surgery, including preoperative and postoperative care	50%	50%	50%
Minor Restorative Services—Used to repair teeth damaged by disease or injury (for example, fillings)	50%	50%	50%
Periodontics—Used to treat diseases of the gums and supporting structures of the teeth	50%	50%	50%
Endodontics—Used to treat teeth with diseased or damaged nerves (for example, root canals)	50%	50%	50%
CLASS III			
Major Restorative Services—Used when teeth cannot be restored with another filling material (for example, crowns)	25%	25%	25%
Prosthodontics—Used to replace missing natural teeth (for example, bridges, endosteal implants, and dentures)	25%	25%	25%
Maximum Payment—The per person total per calendar year for Class I, Class II and Class III Benefits is:	$1,250	$750	$750
Deductible—$50 per person total per calendar year on Class II and Class III Benefits. The deductible does not apply to Class I Benefits.			

* Coverage levels are based on the following: Delta Dental PPO—based on dentist's submitted fee or the amount in the local Delta Dental's PPO dentist fee schedule, whichever is less; Delta Dental Premier®—based on dentist's submitted fee or the maximum approved fee for Delta Dental's Premier dentist fee schedule, whichever is less; and Non-participating—based on dentist's submitted fee or Delta Dental's non-participating dentist fee, whichever is less.

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Optional Dental Coverage

Benefit Features For Optional Dental Benefits—Low Plan

Under Delta Dental PPO℠, Delta Dental of Michigan's payment for covered services will be based on the local Delta Dental PPO fee schedule. You can go to any licensed Delta Dental PPO dentist. Delta Dental's participating PPO dentists agree to charge no more than the Delta Dental PPO fee scheduled amount for covered services. Services provided by a non-participating dentist are not covered.

Delta Dental PPO (Standard)		
	Plan Pays*	
	Delta Dental PPO Dentist*	Non-participating Dentist**
CLASS I		
Diagnostic and Preventive Services—Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments)	100%	0%
Emergency Palliative Treatment—Used to temporarily relieve pain	100%	0%
Radiographs—X-rays	100%	0%
CLASS II		
Oral Surgery—Extractions and dental surgery, including preoperative and postoperative care	50%	0%
Minor Restorative Services—Used to repair teeth damaged by disease or injury (for example, fillings)	50%	0%
Periodontics—Used to treat diseases of the gums and supporting structures of the teeth	50%	0%
Endodontics—Used to treat teeth with diseased or damaged nerves (for example, root canals)	50%	0%
Maximum Payment—$1,000 per person total per calendar year for Class I and Class II Benefits.		
Deductible—$50 per person total per calendar year on Class II Benefits. The deductible does not apply to Class I Benefits.		

* Coverage levels for Delta Dental PPO are based on dentist's submitted fee or the amount in the local Delta Dental's PPO dentist fee schedule, whichever is less. **There is no out-of-network coverage except for certain emergency services associated with the emergency treatment of dental pain or a problem-focused exam.

Delta Dental Plan of Michigan, Inc. • P.O. Box 30416, Lansing, MI 48909
Customer Service (800) 971-4108 • www.deltadentalmi.com

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 (800) 971-4108.

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DELTA DENTAL®

Questions And Answers About Delta Dental PPO℠ (Point Of Service)—Optional Dental Benefits—High & Medium Plans

What is Delta Dental PPO (Point-of-Service)?
Delta Dental PPO (Point-of-Service) is Delta Dental Plan of Michigan, Inc.'s national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists—our Delta Dental PPO network and our Delta Dental Premier® network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.

Nationwide, more than 72,000 dentists participate in the Delta Dental PPO network, and more than 132,000 dentists participate in the Delta Dental Premier® network.

What are the advantages of choosing a Delta Dental PPO dentist?
You will receive the highest level of coverage for some services when you go to a Delta Dental PPO participating dentist. In addition, Delta Dental pays PPO dentists directly for covered services based on submitted fees or the amount listed in the local Delta Dental PPO fee schedule, whichever is less. If the Delta Dental PPO fee schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a Delta Dental PPO dentist for covered services. Delta Dental PPO dentists also will fill out and file your claim forms, which means fewer hassles for you.

What are the advantages of choosing a Delta Dental Premier® dentist?
Although you will receive a lower level of coverage for some services when you go to a Delta Dental Premier® dentist, Delta Dental will pay the participating dentist directly for covered services based on submitted fees or the local Delta Dental maximum approved fee, whichever is less. If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference.

As with Delta Dental PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Delta Dental Premier® dentist for covered services. And, like Delta Dental PPO dentists, Delta Dental Premier® dentists will fill out and file your claim forms for you.

What if I go to a non-participating dentist?
If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier®, you will still be covered, but you may have to pay more. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's non-participating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges. You also may have to submit your own claims.

Optional Dental Coverage

DELTA DENTAL®

Do I need an ID card to receive care?
No. Your dentist can verify your eligibility for coverage 24/7 by checking the online Dental Office Toolkit® or by calling the DASI (Delta Dental's Automated Service Inquiry) system. If you would like an ID card for reference purposes, you can use Delta Dental's online Consumer Toolkit® (www.deltadentalmi.com) to print one.

What if I have other questions?
Please call Delta Dental's Customer Service department toll-free at (800) 971-4108. Delta Dental's DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims, and eligibility information, Delta Dental's mailing address, and the names of participating dentists near you. In addition, Customer Service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. EST.

If you have Internet access, you also can use Delta Dental's Web-based Consumer Toolkit (www.deltadentalmi.com) to access your own benefit, claims, and eligibility information 24/7. You can use this Toolkit to search dentist directories, print ID cards and claim forms, sign up for paperless delivery of your Explanation of Benefit (EOB) statements, and read oral health tips.

DELTA DENTAL®

Questions And Answers About Delta Dental PPO℠ (Standard)—Optional Dental Benefits—Low Plan

What is Delta Dental PPO (Standard)?
Delta Dental PPO (Standard) is a national preferred provider organization program administered by Delta Dental Plan of Michigan, Inc. Services provided by a Delta Dental PPO participating dentist are covered under this plan, however, services provided by a dentist who does not participate in Delta Dental PPO are not covered.

What are the advantages of utilizing a Delta Dental PPO dentist?
When you utilize a Delta Dental PPO participating dentist for covered services, we will pay that dentist directly based on submitted fees or the amount in the local Delta Dental PPO fee schedule, whichever is less. If the Delta Dental PPO fee schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you receive covered services from a Delta Dental PPO dentist. Delta Dental's PPO dentists also will fill out and file your claim forms, which means fewer hassles for you.

How can I find a Delta Dental PPO dentist?
To get the names of Delta Dental PPO dentists near you, call Delta Dental's Customer Service department at (800) 971-4108. Delta Dental's DASI (Delta Dental's Automated Service Inquiry) system is available 24/7 and can provide you with the names of Delta Dental PPO dentists near you. You also can visit the Delta Dental Web site at www.deltadentalmi.com.

What if I go to a dentist who does not participate in Delta Dental PPO?
Services provided by a dentist who does not participate in Delta Dental PPO are not covered under this plan. If you receive dental services from a dentist who does not participate in Delta Dental PPO, you will be responsible for paying the dentist whatever he or she charges. No payment will be made by Delta Dental.

Do I need to tell my dentist my coverage has changed?
Yes, it would be helpful if you told your dentist that you have Delta Dental PPO coverage through Delta Dental of Michigan.

Do I need an ID card to receive care?
No. Your dentist can verify your eligibility for coverage 24/7 by checking Delta Dental's online Dental Office Toolkit® or by calling DASI. If you would like an ID card for reference purposes, you can use Delta Dental's online Consumer Toolkit® at www.deltadentalmi.com to print one.

What if I have other questions?
Please call Delta Dental's Customer Service department at (800) 971-4108. Delta Dental's DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims, and eligibility information, Delta Dental's mailing address, and the names of Delta Dental PPO dentists near you. In addition, Customer Service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. EST.

If you have Internet access, you can also use Delta Dental's Web-based Consumer Toolkit (www.deltadentalmi.com) to access your own benefit, claims, and eligibility information 24/7. You can also use this Toolkit to search dentist directories, print ID cards and claim forms, sign up for electronic delivery of your Explanation of Benefit (EOB) statements, and read oral health tips.

Things To Know

Medical Underwriting Requirements

Alliance Health and Life Insurance Company (Alliance) individually underwrites each application based on your health history and current health status. Alliance uses your health and medical information to determine the outcome of your application for health coverage, a waiting period for any applicable pre-existing conditions, and the premium charged for your coverage under the policy.

In some instances, a follow-up medical questionnaire, and/or telephone call, and/or e-mail may be required to verify information. Medical records may be requested and independent information gathered from other insurance industry entities.

Michigan law prohibits genetic testing before issuing, renewing or continuing a policy or certificate in this state. The law also prohibits disclosure of genetic testing as to whether it has been conducted or the results of testing or information.

Duplicate Coverage

Do not cancel your current insurance until you are notified that you have been accepted for coverage. If you are currently covered by another carrier, you must agree to discontinue the other coverage prior to or on the effective date of the HAP SOLO plan.

Pre-existing Conditions

A pre-existing condition is a sickness or bodily injury for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the covered person's effective date of coverage. Pre-existing condition exclusions do not apply to members who are 18 years old or younger. Benefits for pre-existing conditions are not payable until coverage has been in force for 12 consecutive months with HAP. If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion may be reduced or waived. If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63-day gap from the date your prior coverage terminated to your enrollment date), we will apply the pre-existing condition exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have received from your previous health insurer.

Terms of Coverage

Coverage remains in effect as long as you pay the required premiums on time, and as long as you maintain membership eligibility. Coverage will be terminated if you become ineligible due to:

- Non-payment of premiums
- Obtaining duplicate coverage
- For other reasons permissible by law

Dental benefit coverage questions should be directed to Delta Dental by either using their Web site, www.deltadentalmi.com or by calling Delta Dental customer service toll-free at **800-971-4108**.

Limitations & Exclusions

Non-covered services

The following is a partial list of services and supplies that are generally not covered. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

1. Services rendered or expenses incurred prior to your effective date of enrollment, or after cancellation of coverage, services or benefits that are not expressly included in the policy, or services and supplies not medically necessary, as defined by Alliance Health and Life.
2. Non-emergent services provided in an emergency setting.
3. Reproductive Care and Family Planning Services—related to diagnosis, counseling and treatment of infertility, voluntary sterilization such as vasectomy or tubal ligation, voluntary termination of pregnancy, biologicals, contraceptive implant systems and devices.
4. Sex-change procedures.
5. Cosmetic services.
6. Weight-loss programs and services.
7. Experimental and investigational services.
8. Eye care and vision services (routine eye exams are covered).
9. Foot care.
10. Mental health and chemical dependency—in excess of the maximum benefit, custodial care, marriage counseling, phone consultations, etc.
11. Nursing services—private duty nursing services, residential and basic nursing services provided in a long-term care facility.
12. Oral, maxillofacial and dentistry services.
13. Dietary drugs, food and food supplements.
14. Therapy and rehabilitation services—beyond the authorized visit limit as approved by Alliance, genetic testing, premarital exams, classes, or marriage counseling, etc.
15. Any services, procedures, supplies, drugs or devices related to life-style improvements, including but not limited to smoking cessation (nicotine habit or addiction), wellness programs or physical fitness programs, or cosmetic appearance alterations.
16. Services for military-related injuries or disabilities, for which you are legally entitled to receive services, payment or reimbursement from the United States or any state or political subdivision thereof.
17. Services required by a third party.
18. Services provided if you are in police custody, unless an emergency exists or such benefits and services are provided at an affiliated hospital by an affiliated physician.
19. Services for any injury, illness, or condition that results from or to which a contributing cause was your commission of or attempt to commit a crime, or engagement in illegal occupations.

To view our Privacy Policy, go to **hap.org/info/privacy.php**

Glossary

Copayment or copay — A fixed fee that you must pay for services covered by the health plan.

Coinsurance — Costs shared by you and your insurance plan after the deductible is met (i.e., 70/30).

Deductible — The amount of money you must pay before the plan coverage begins.

HAP Advantage — Health Alliance Plan program that offers valuable money-saving discounts and extras to members on a variety of health and wellness-related activities, venues, and Web sites.

In-Network — Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount.

Mental Health Services — Benefits that provide integrated and confidential behavioral disease management to ensure a holistic approach to helping members with mental health and medical conditions.

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

Out-of-Pocket — Portion of health care services or health care costs that must be paid for by the plan member, including deductibles, copayments and coinsurance.

Preferred Provider Organization (PPO) — A network of health care providers with which a health insurer has negotiated contracts for its members to receive health services at discounted costs.

Premium — The amount you or your employer pays in exchange for health insurance coverage.

Rx — A common abbreviation for a prescription written by a physician for medication or equipment.

Flexible coverage for individuals and families.

hap.org/solo

SOLO is a product of Alliance Health and Life Insurance Company, Inc, a wholly owned subsidiary of Health Alliance Plan.

SOLO is a medically underwritten health plan, which means acceptance into a SOLO plan and your monthly rate are based on your health history.