SOLO powered by hap

Health Coverage for Individuals and Families

Ready to go SOLO?

Your Guide to Understanding and Selecting Your Individual Health Plan

www.hap.org/SOLO

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

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

Why SOLO powered by hap?

You'll discover more in this booklet about the benefits of an individual health plan. But let's start at the beginning. What is an individual health plan – and why choose one from HAP? The answer to both is simple.

An ***individual health plan*** is health coverage for any individual or family not covered by an employer. You may need an individual health plan if you're self-employed or between jobs. Perhaps you work part-time, just graduated from college or retired early. You may even be looking for options other than COBRA. If you need quality health coverage that's also affordable, this plan is for you.

So, why choose SOLO? We're glad you asked:

- **It's affordable.**
  SOLO provides Michigan residents and their families with affordable health insurance coverage from Southeast Michigan's most experienced health plan.

- **It's flexible.**
  If you're a Michigan resident, SOLO can meet your health needs and budget by offering the flexibility to choose deductibles, co-insurance and out-of-pocket maximums. SOLO also gives you the flexibility to choose your doctors and hospitals.

- **It's solid.**
  When you go SOLO, you're backed by the stability of Michigan's most trusted local health plan. You also gain access to our broad network of doctors and hospitals.

- **It's easy.**
  SOLO is the only local individual health plan in Michigan to offer enrollment completely online. It can take less than 30 minutes to apply, and coverage can begin as soon as the first day of the month following acceptance. (Wow! Fast *and* easy!)

- **It's got extras.**
  SOLO offers plans with tax-free Health Savings Accounts (HSAs), which can be used to pay for medical expenses and to save for retirement health care costs. We have fully integrated the HSA with your health plan so you'll have the ease of using a debit card or checkbook to access your HSA funds. In addition, you get special discounts on services such as LASIK and Weight Watchers® through our HAP Advantage program.

How to use this brochure

SOLO was created around you and your needs, no matter what's happening in your life. We call it SOLO because it's all about you. And it's powered by HAP, the name trusted for health coverage for generations.

Take a few minutes to review this brochure. You'll find all the information you need to understand – and select – your individual insurance. And you'll get answers to all your questions when choosing your individual health plan:

- **What plans does SOLO offer?**
- **What are the key features of SOLO?**
- **What's the best plan for my life situation?**
- **Is an HSA right for me?**
- **How do I enroll in an HSA?**
- **Is it really that easy to enroll in SOLO?**

Okay, let's just answer that last question right now.

Yes! Follow these simple steps:

1. Visit us at www.hap.org/SOLO
2. Compare plans and shop prices
3. Choose the plan that best fits you and request a quote
4. Complete and submit your application

Before you apply, please have the following items available for each person applying for coverage:

- Birth date, Social Security number (SSN), and height/weight
- Information on current and past health insurance plans (if applicable)
- Medical history including dates of diagnosis, treatment, dates of service and current status
- Prescription drug information including drug names, dosages and date initially prescribed

Payment information: We accept VISA and MasterCard for credit card payments. For electronic funds transfer (EFT), please have your checking account number and bank routing number.

That's all there is to it. You're done in about half an hour, entirely online. No paper, no pen, no stamps. We figure, why make things difficult when you can keep them as simple as SOLO?

Now, read on to learn how you can go SOLO.

Right where you need us most

When you go SOLO, you're not alone. You'll get access to the thousands of physicians, hospitals and other providers – all part of an extensive network of **leading doctors and hospitals** in Southeast Michigan alone.

In addition to the thousands of local providers you have access to, we contract with MultiPlan, a preferred network to provide nationwide coverage when you travel outside of our service area or out-of-state for emergent/ urgent medical care.

Just check out the choices. Now, you know what we mean when we say SOLO is powered by HAP.

Everyone loves options

SOLO has a range of plan designs for individuals and families, and you don't need a referral to see a doctor. When you go SOLO, you're the boss.

If you want coverage, but need to keep your monthly costs to a minimum, SOLO is for you. Our HSA plans can be a perfect fit if you want to control where your dollars go – and when they stay in your pocket. SOLO offers both in-network and out-of-network benefits.

The bottom line is, going SOLO gives you and your family options. It doesn't matter if you're an individual, couple or family, SOLO is all about you and your health.

Everything you're looking for

Imagine a health plan with everything you want:

- Choice of plans to fit your budget and your life
- Online enrollment and payment
- Optional Health Savings Account (HSA)
- Flexible plan designs
- Prescription drug coverage options
- Optional dental benefits from Delta Dental
- Optional maternity rider
- Affordable pricing
- And some really cool internet tools to help you manage your care

Not surprisingly, SOLO is easy to get and easy to like.

SOLO is Adaptive. Flexible. Versatile. The best way to describe it is, it's just like you.

Are you going SOLO?

If you're not covered by a group health plan, go SOLO. Our plans are perfect for individuals and families, especially if you are:

- **A recent college graduate**
- **Getting married**
- **Raising a family**
- **Self-employed**
- **Between jobs**
- **Empty nesters**
- **Retiring early**

Which plan fits your needs?

Maybe you're young and just out of college. Or you just retired early from your firm. You're between jobs and just about at the end of your COBRA coverage. Don't worry. SOLO has a plan for you.

SOLO offers Preferred Provider Organization (PPO) plans that can be paired with a Health Savings Account (HSA).

A PPO plan offers you the freedom to access our broad PPO network of doctors and hospitals. If the doctor or hospital you choose is not in HAP's PPO network, HAP will cover a smaller portion of the total costs.

Not sure which plan to choose? Here are some suggestions on which plan is right for your situation.

You're the hot shot now. All that studying finally paid off with a college degree. You're young. You're ambitious. You're also off your parents' health insurance. No problem. Your first post-graduate decision is which SOLO plan fits your budget.

You're looking for: Affordability, Low Out-Of-Pocket Costs

RECENT COLLEGE GRADUATES

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO PPO 3000 - No Rx
You are looking for low monthly payments.

SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO PPO 1200
You'd like to keep a balance between coverage and cost.

The cake's gone, the "thank you" notes are out. That means the honeymoon is over. Now you have to find a health plan for your new family. But which one?
Oh no, your first real-life decision as newlyweds!
Relax, SOLO can help.

You're looking for: Quality, Affordability

GETTING MARRIED

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO PPO 1000 - Rx Deductible
You'd like to keep a balance between coverage and cost.

SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO PPO 1200
You'd like to keep a balance between coverage and cost.

SOLO PPO 2500
You are looking for low monthly premiums.

SOLO PPO HSA 2500
You want a plan that works with an HSA.

Baby blues, toothless grins and midnight runs for diapers. My, how life has changed. At least you won't be up all night thinking about your health coverage, because our range of plans gives peace of mind. It's a new twist on the old adage: you and me and SOLO makes three.

You're looking for:
Low Out-Of-Pocket Costs, Strong Coverage

RAISING A FAMILY

SOLO 1st Dollar Network - Rx
You're willing to see only participating network providers for lower monthly payments.

SOLO PPO 500
You visit the doctor but want to keep out-of-pockets costs low.

SOLO PPO 1000 - Rx Deductible
You'd like to keep a balance between coverage and cost.

SOLO PPO 1200
You'd like to keep a balance between coverage and cost.

SOLO PPO 2500
You are looking for low monthly premiums.

You're self-employed. Congratulations, you're the boss!
Now you get to make the tough decisions, like which health coverage to get.

You're looking for:
Strong Coverage, Low Monthly Payments

SELF-EMPLOYED

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO 1st Dollar Network - No Rx
You're willing to see only participating network providers for lower monthly payments.

SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO PPO 3000 - Rx
You are looking for low monthly payments.

SOLO PPO 2500
You are looking for low monthly premiums.

SOLO PPO HSA 2500
You want a plan that works with an HSA.

It doesn't matter how you ended up between jobs; it only matters that you are. And that means no health coverage, except maybe COBRA. You could probably use a helping hand right about now.

You're looking for:
Low Monthly Payments, Low Out-Of-Pocket Costs

BETWEEN JOBS

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO PPO 3000 - No Rx
You are looking for low monthly payments.

SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO PPO 1000 - No Rx
You like to keep a balance between coverage and cost.

SOLO PPO HSA 2500
You want a plan that works with an HSA.

Ah, the sweet sound of silence. The kids are gone and it's finally just the two of you. Better check your health coverage and make sure it's tailor-made for two.

You're looking for:
Strong Coverage, Reasonable Out-of-Pocket Costs

EMPTY NESTERS

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO 1st Dollar Network - Rx
You're willing to see only participating network providers for lower monthly payments.

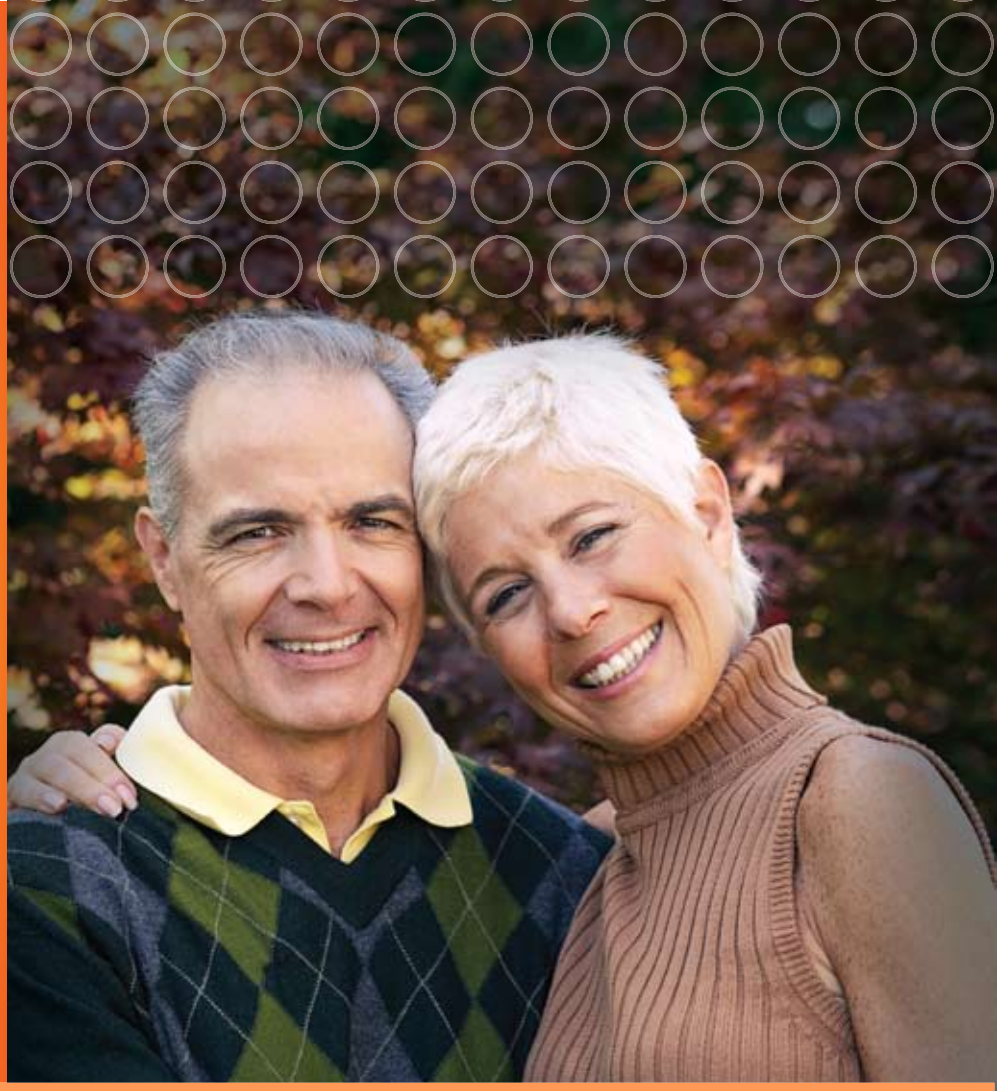
SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO PPO 1000 - Rx
You'd like to keep a balance between coverage and cost.

SOLO PPO 2500
You are looking for low monthly premiums.

SOLO PPO HSA 2500
You want a plan that works with an HSA.

You've paid your dues, now it's your time to travel and hit the links. Just one problem. You don't get company insurance anymore and you're too young for Medicare. Good thing SOLO is watching out for you.



You're looking for:
Strong Coverage, Reasonable Out-of-Pocket Costs

RETIRING EARLY

SOLO PPO 5000
You only see a doctor for basic health care needs and want low monthly payments.

SOLO PPO 3000 - Rx
You are looking for low monthly payments.

SOLO PPO 500
You visit the doctor but want to keep out-of-pocket costs low.

SOLO 1st Dollar Network - Rx
You're willing to see only participating network providers for lower monthly payments.

SOLO PPO 2500
You are looking for low monthly premiums.

SOLO PPO HSA 2500
You want a plan that works with an HSA.

Is an HSA Right for Me? Why choose a Health Savings Account (HSA)?

Consider an HSA your health care "piggy bank." It's flexible, portable and has powerful tax advantages.

What is a Health Savings Account (HSA)?

HSAs are the first medical savings accounts that are both cumulative and portable. The balance in an HSA rolls over from year to year, and the account stays with you if you switch health insurers or retire. HAP's preferred HSA partner is the ACS/Mellon HSA Solution®. In 2005, *FORTUNE* magazine rated Mellon #1 among the most admired financial institutions. ACS provides the administration and technology allowing you to get the information and answers you need right when you need them. *FORTUNE* magazine rated ACS #4 among the most admired computer and data services companies in 2005.

HSAs are tax-exempt savings vehicles that work in conjunction with a high-deductible health plan. These special tax-sheltered savings accounts are designated for medical expenses. An HSA allows you to pay for current qualified health expenses and save for future qualified medical and retiree health care expenses on a tax-free basis. Contributions and earnings are exempt from federal and most state income taxes, as well as Social Security (FICA) taxes. These tax savings also apply to all distributions when used to pay for qualified medical expenses. You can even use your HSA dollars to pay for medical expenses not covered under your health plan, such as dental, vision and alternative medical expenses. Unlike a flexible spending account (FSA), unused HSA contributions roll over from year to year and accumulate for future health care expenses.

Source: The ACS/Mellon HSA Solution, 2006

What is a "high-deductible health plan" (HDHP)?

An HDHP is a health insurance plan with minimum annual deductibles of $1,150 for individuals or $2,300 for family coverage. The annual out-of-pocket expense maximums (including deductibles, co-insurance and copayments but not including premiums) cannot exceed $5,800 for individuals or $11,600 for families. These amounts (for 2009) are indexed annually for inflation.

Why establish an HSA?

HSAs are:

Tax-advantaged: Contributions, earnings and withdrawals (for qualified medical expenses) are not taxed.

Flexible & Portable: Accounts move with you if you change insurers or retire.

A savings mechanism for future health needs: Unused contributions accumulate and can be "banked" for future qualified medical expenses.

No "use it or lose it"

Unlike other medical savings accounts, the HSA has no provision insisting you "use or lose" your account dollars at the year's end. Any funds you do not use in a given plan year remain in your account, building a larger checking or "transactional" account for future health care expenses.

Growing your HSA

Each year, you may contribute an amount up to your health care plan deductible or the annual IRS limit, whichever is less. For 2009, that maximum equals $3,000 for individuals, or $5,950 for a family. If you are age 55 or older, you may make additional catch-up contributions of up to $1,000.

Invest your savings

The ACS/Mellon HSA Solution offers an integrated investment platform with 20 investment options from a variety of fund families. You can open investments online for as little as $1 once your HSA checking balance reaches $2,000.

HSA participants also have the option *not* to use their HSA balances for health care and pharmacy charges. Account holders may instead pay out-of-pocket expenses with after-tax dollars allowing their HSA balances to grow tax-free.

How does an HSA work?

All the money you deposit into an HSA under the annual contribution limit is 100 percent tax-deductible. You pay expenses with tax-advantaged money from the HSA until you meet your deductible, and your health care coverage pays covered expenses in excess of the deductible amount.

The idea is simple: You can use your HSA to pay for your health care costs, from doctor and hospital visits to copayments, eyeglasses and prescriptions. Even better, *covered health care expenses* 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 accident or injury – exceed your health plan deductible, an out-of-pocket maximum "caps" your costs, but leaves your coverage in place.

To access a full list of qualified health care expenses, consult IRS Publication 502: Medical and Dental Expenses on the IRS Web site at www.irs.gov.

Source: The ACS/Mellon HSA Solution, 2006

Paying for care

ACS/Mellon offers the convenience of multiple payment options for quick transactions with minimal paperwork. You can pay your health care expenses:

- **By check from your HSA checking account**
- **By HSA debit card**
- **By electronic claims processing, in which HAP withdraws money from your HSA and pays the provider on your behalf**

Managing your HSA

Keeping track of your HSA is easy. You will receive monthly statements by mail summarizing your account activities:

- **Deposits**
- **Withdrawals**
- **Fees (if applicable)**
- **Interest/investment earnings**

In addition, the ACS/Mellon HSA member Web site gives you access to your HSA information, updated daily. The Web site also allows you to re-order statements or checks. You can set alerts to be notified if your account balances reach a certain level or as a transaction processes.

Who can open an HSA?

The Medicare Act of 2003 included a section allowing "eligible individuals" to establish HSAs beginning January 1, 2004. Eligible individuals:

- **Must be covered by a high-deductible health plan**
- **Cannot be covered by a medical plan that is not a high-deductible health plan (dental and vision plans are not included in this restriction)**
- **Cannot be enrolled in Medicare, and**
- **Cannot be claimed as a dependent on another individual's tax return**

Getting started

While you may open an HSA with any institution of your choice, we have arranged for you to establish your SOLO HSA health plan and initiate the process of opening an HSA withACS/Mellon Financial all in one easy step.

- **Apply online for any one of SOLO's HSA plans**
- **Fill out the "Request for a Health Savings Account (HSA) – AUTHORIZATION FORM" within your SOLO application form**
- **ACS/Mellon will send you a Welcome Kit with information about your HSA and account terms and conditions, and a signature card you'll need to sign and return toACS/Mellon.**

Please note: An ACS/Mellon HSA Solution Welcome Kit will be sent once your SOLO HSA health plan is activated and payment is received. If this health plan is not approved and activated by Alliance Health and Life Insurance Company, you will not receive an HSA Welcome Kit.

Check out theACS/Mellon Web site at www.hsamember.com

This is not intended to be a complete summary of all provisions relating to Health Savings Accounts (HSAs).

Source: The ACS/Mellon HSA Solution, 2006

Just what's covered in your SOLO health plan? Check out our plan designs below to find out how our plans work for you.

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PREFERRED PROVIDER ORGANIZATION (PPO) SUMMARY OF BENEFITS

This Summary of Benefits is designed to provide an overview of the Alliance 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. Alliance PPO Subscribers and Dependants who do not seek services from a network provider will receive services at the Out-of-Network benefit level.

SOLO PPO Plans

	DEDUCTIBLE		Co-insurance		OUT-OF-POCKET MAXIMUM		LIFETIME BENEFIT MAX
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
SOLO 500	$500/$1,000	$1,000/$2,000	70%	50%	$3,000/$6,000	$6,000/$12,000	$5 Million
SOLO 1200	$1,200/$2,400	$2,400/$4,800	70%	50%	$5,200/$10,400	$10,400/$20,800	$5 Million
SOLO 2500	$2,500/$5,000	$5,000/$10,000	80%	50%	$6,500/$13,000	$13,000/$26,000	$5 Million
SOLO 5000	$5,000/$10,000	$10,000/$20,000	80%	50%	$10,000/$20,000	$20,000/$40,000	$5 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	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	Subject to co-insurance	Not Covered	Limited to $500 per person per calendar 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	Subject to deductible and co-insurance	Subject to deductible and co-insurance	1 Manipulation of the spine for sublux-ation only; 20 visits per person per calendar year 2 Does not include lenses / frames / contacts
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 3	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Must meet Alliance emergency guide-lines 3 Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
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 co-insurance	Subject to deductible and co-insurance	
Ancillary Services* Home Health Care 4 Hospice Care 5 Physical Therapy, Speech Therapy, Occupational Therapy 6 Durable Medical Equipment (DME) 7 Prosthetics and Orthotics 8 Skilled Nursing Facility 9	Subject to deductible and co-insurance	Subject to deductible and co-insurance	* Limitations are a combination of in-and out-of-network services 4 100 visits per calendar year 5 210 days lifetime 6 60 visits combined 7 Must be an authorized piece of equipment based on Alliance guidelines 8 Must be an authorized piece of equipment based on Alliance guidelines 9 100 days per calendar year
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755; Limited to $2,500 per person per calendar year
Mental Health Services Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Limited to $500 per person per calendar year
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Up to state-mandated benefit per person per calendar year
Prescription Drugs	Generic $15 Preferred $30 Non-preferred $50	Generic $15 Preferred $30 Non-preferred $50	Oral contraceptives and devices included
Maternity Services Pre-Natal Care Routine Labor and Delivery and Post-Partum In-Hospital Care of Well Newborn	Not Covered	Not Covered	Optional rider available
Precertification Penalty			If precertification procedures are not followed, inpatient benefits will be subject to a $250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of $250. The penalty does not apply toward satisfying the out-of- pocket maximum. This penalty is imposed for each incidence of non-compliance.

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HEALTH SAVINGS ACCOUNT – PREFERRED PROVIDER ORGANIZATION (HSA PPO) SUMMARY OF BENEFITS

This Summary of Benefits is designed to provide an overview of the Alliance SOLO HSA PPO 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 HSA PPO Plans

	DEDUCTIBLE		Co-insurance		OUT-OF-POCKET-MAXIMUM		LIFETIME BENEFIT MAX
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
SOLO HSA 2500	$2,500/$5,000	$5,000/$10,000	80%	50%	$5,000/$10,000	$10,000/$20,000	$5 Million
SOLO HSA 5000	$5,000/$10,000	$10,000/$20,000	100%	50%	$5,000/$10,000	$20,000/$40,000	$5 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	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	Subject to co-insurance	Not Covered	Limited to $500 per person per calendar 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	Subject to deductible and co-insurance	Subject to deductible and co-insurance	1 Manipulation of the spine for subluxation only; 20 visits per person per calendar year 2 Does not include lenses / frames / contacts
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 3	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Must meet Alliance emergency guidelines 3 Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
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 co-insurance	Subject to deductible and co-insurance	
Ancillary Services* Home Health Care 4 Hospice Care 5 Physical Therapy, Speech Therapy, Occupational Therapy 6 Durable Medical Equipment (DME) 7 Prosthetics and Orthotics 8 Skilled Nursing Facility 9	Subject to deductible and co-insurance	Subject to deductible and co-insurance	* Limitations are a combination of in-and out-of-network services 4 100 visits per calendar year 5 210 days lifetime 6 60 visits combined 7 Must be an authorized piece of equipment based on alliance guidelines 8 Must be an authorized piece of equipment based on alliance guidelines 9 100 days per calendar year
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755; limited to $2,500 per person per calendar year
Mental Health Services Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Limited to $500 per person per calendar year
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Up to state-mandated benefit per person per calendar year
Prescription Drugs	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Oral contraceptives and devices included
Maternity Services Pre-Natal Care Routine Labor and Delivery and Post-Partum In-Hospital Care of Well Newborn	Not Covered	Not Covered	Optional rider available
Precertification Penalty			If precertification procedures are not followed, inpatient benefits will be subject to a $250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of $250. The penalty does not apply toward satisfying the out-of-pocket maximum. This penalty is imposed for each incidence of non-compliance.

PREFERRED PROVIDER ORGANIZATION (PPO) SUMMARY OF BENEFITS

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SOLO PPO 1000 Plans

	DEDUCTIBLE		Co-insurance		OUT-OF-POCKET MAXIMUM		LIFETIME BENEFIT MAX
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
SOLO 1000 Rx Deductible	$1,000/$2,000	$2,000/$4,000	70%	50%	$5,000/$10,000	$10,000/$20,000	$5 Million
SOLO 1000 No Rx	$1,000/$2,000	$2,000/$4,000	70%	50%	$5,000/$10,000	$10,000/$20,000	$5 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	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	Subject to co-insurance	Not Covered	Limited to $500 per person per calendar 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	Subject to deductible and co-insurance	Subject to deductible and co-insurance	1 Manipulation of the spine for sublux-ation only; 20 visits per person per calendar year 2 Does not include lenses / frames / contacts
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 3	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Must meet Alliance emergency guidelines 3 Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
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 co-insurance	Subject to deductible and co-insurance	
Ancillary Services* Home Health Care 4 Hospice Care 5 Physical Therapy, Speech Therapy, Occupational Therapy 6 Durable Medical Equipment (DME) 7 Prosthetics and Orthotics 8 Skilled Nursing Facility 9	Subject to deductible and co-insurance	Subject to deductible and co-insurance	* Limitations are a combination of in-and out-of-network services 4 100 visits per calendar year 5 210 days lifetime 6 60 visits combined 7 Must be an authorized piece of equipment based on Alliance guidelines 8 Must be an authorized piece of equipment based on Alliance guidelines 9 100 days per calendar year
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Mental Health Services Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Limited to $500 per person per calendar year
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible and co-insurance	Subject to deductible and co-insurance	Up to state-mandated benefit per person per calendar year
Prescription Drugs	PPO 1000 Rx Deductible Plan $500 per person deductible then member pays copay Generic $15 Preferred $30 Non-preferred $50		Oral contraceptives and devices included if Prescriptions are Covered PPO 1000 No Rx - Prescriptions Not Covered
Maternity Services Pre-Natal Care Routine Labor and Delivery and Post-Partum In-Hospital Care of Well Newborn	Not Covered	Not Covered	Optional rider available
Precertification Penalty			If precertification procedures are not followed, inpatient benefits will be subject to a $250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of $250. The penalty does not apply toward satisfying the out-of-pocket maximum. This penalty is imposed for each incidence of non-compliance.

PREFERRED PROVIDER ORGANIZATION (PPO) SUMMARY OF BENEFITS

This Summary of Benefits is designed to provide an overview of the Alliance 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. Alliance PPO Subscribers and Dependants who do not seek services from a network provider will receive services at the Out-of-Network benefit level.

SOLO PPO 3000 Plans

	DEDUCTIBLE		Co-insurance		OUT-OF-POCKET MAXIMUM		LIFETIME BENEFIT MAX
	In-Network Individual	Out-of-Network Individual	In-Network	Out-of-Network	In-Network Individual	Out-of-Network Individual	
SOLO 3000 Rx	$3,000 (combined)		100%	50%	$3,000	$10,000	$5 Million
SOLO 3000 No Rx	$3,000 (combined)		100%	50%	$3,000	$10,000	$5 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	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	$25 copay per office visit for 4 visits / calendar year	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

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
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	$25 copay per office visit for 4 visits / calendar year $20 copay / Back Care visit $25 copay on diagnostic lab/x-ray and other hospital outpatient services $100 copay / Outpatient Surgery	50% co-insurance on 4 visits / calendar year 20% co-insurance / Back Care visit 50% co-insurance on diagnostic lab/x-ray and other hospital outpatient services 50% co-insurance / 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
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 3	$100 copay/ER visit $50 copay/Urgent care visit	$100 copay / ER visit $50 copay / Urgent Care visit 50% co-insurance on Ambulance services	Must meet Alliance emergency guidelines ER Copay waived if admitted Copay will not be applied to deductible or out-of-pocket maximum 3 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	Subject to deductible and co-insurance	Inpatient services limited to $50,000 (combined in-and out-of-network) per person per calendar year
Ancillary Services* Home Health Care 4 Hospice Care 5 Physical Therapy, 6 Speech Therapy, Occupational Therapy Durable Medical Equipment (DME) 7 Prosthetics and Orthotics 8 Skilled Nursing Facility 9	Subject to deductible	Subject to deductible and co-insurance	* Limitations are a combination of in-and out-of network services 4 30 visits per calendar year 5 210 days lifetime 6 30 visits combined 7 Must be an authorized piece of equipment based on Alliance guidelines 8 Must be an authorized piece of equipment based on Alliance guidelines 9 100 days per calendar year
Mental Health Services / Chemical Dependency Services Inpatient Services	Subject to deductible	Subject to deductible and co-insurance	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755; Limited to $2,500 per person per calendar year
Mental Health Services Outpatient Services	Subject to deductible	Subject to deductible and co-insurance	Limited to $500 per person per calendar year

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Chemical Dependency Services Residential and Outpatient Services	Subject to deductible	Subject to deductible and co-insurance	Up to state-mandated benefit per person per calendar year
Prescription Drugs	PPO 3000 Rx Plan Generic $15 copay Preferred $30 copay Non-preferred $50 copay		Oral contraceptives and devices included if Prescriptions are Covered Prescription drug benefit limited to $500 per person per calendar year PPO 3000 No Rx - Prescriptions Not Covered
Maternity Services Pre-Natal Care Routine Labor and Delivery and Post-Partum In-Hospital Care of Well Newborn	Not Covered	Not Covered	Optional rider available
Precertification Penalty			If precertification procedures are not followed, inpatient benefits will be subject to a $250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of $250. The penalty does not apply toward satisfying the out-of-pocket maximum. This penalty is imposed for each incidence of non-compliance.

1ST DOLLAR NETWORK PLAN SUMMARY OF BENEFITS

This Summary of Benefits is designed to provide an overview of the Alliance SOLO Network 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 Network Plan

	DEDUCTIBLE		Co-insurance		ANNUAL PLAN MAXIMUM		LIFETIME BENEFIT MAX
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
1st Dollar Network Plan Rx	$0	$0	100%	-	$100,000 (combined)		$1 Million
1st Dollar Network Plan No Rx	$0	$0	100%	-	$100,000 (combined)		$1 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	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	$25 copay / preventive office visit	Not Covered	Preventive office visits limited to 2 per person per calendar year 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	$25 copay / Primary Care office visit $40 copay / Specialist office visit $20 copay / Back Care visit $10 copay / diagnostic test/lab/x-ray $250 copay / Outpatient Surgery	Not Covered	Physician office visitst limited to 4 per person per calendar year 1 Manipulation of the spine for sub-luxation only; 20 visits per person calendar year 2 Does not include lenses / frames / contacts

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Emergency Services Emergency Room Services Urgent Care Facility Services Emergency Ambulance Services 3	$250 copay / ER visit $100 copay / Urgent Care visit		Must meet Alliance emergency guidelines ER Copay waived if admitted, however $750 Inpatient copay will apply 3 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	$750 copay per admission	Not Covered	
Ancillary Services Home Health Care 4 Hospice Care 5 Physical Therapy, Speech Therapy, Occupational Therapy 6 Durable Medical Equipment (DME) 7 Prosthetics and Orthotics 8 Skilled Nursing Facility 9	Covered Covered $25 copay $40 copay $750 copay per admission	Not Covered	4 30 visits per calendar year 5 210 days lifetime 6 30 visits combined 7 Must be an authorized piece of equipment based on Alliance guidelines 8 Must be an authorized piece of equipment based on Alliance guidelines 9 100 days per calendar year
Mental Health Services / Chemical Dependency Services Inpatient Services	$750 copay per admission	Not Covered	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755.
Mental Health Services Outpatient Services	$40 copay / office visit	Not Covered	
Chemical Dependency Services Residential and Outpatient Services	$40 copay / office visit	Not Covered	Up to state-mandated benefit
Prescription Drugs	1st Dollar Network Rx Plan Generic $10 copay Brand $50 copay **subject to formulary**		Oral contraceptives and devices included if Prescriptions are Covered 1st Dollar Network No Rx Plan - Prescriptions Not Covered

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Maternity Services Pre-Natal Care Routine Labor and Delivery and Post-Partum In-Hospital Care of Well Newborn	Not Covered	Not Covered	Optional rider available
Precertification Penalty			If precertification procedures are not followed, inpatient benefits will be subject to a $250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of $250. This penalty is imposed for each incidence of non-compliance.

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.

HIGH PLAN	MEDIUM PLAN	LOW PLAN
Benefit Feature Sheet	Benefit Feature Sheet	Benefit Feature Sheet
Delta Dental PPO (Point-of-Service) FAQ	Delta Dental PPO (Point-of-Service) FAQ	Delta Dental PPO (Standard) FAQ

Call us toll-free for more information

Learn more about our dental benefits by talking with a Delta Dental representative at (800) 971-4108. You also may access our 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.

DELTA DENTAL

BENEFIT FEATURES FOR OPTIONAL DENTAL BENEFITS—HIGH

Delta Dental PPO℠ (Point-of-Service) 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®, our 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	Nonparticipating 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 Nonparticipating—based on dentist's submitted fee or Delta Dental's nonparticipating 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

Delta Dental PPO℠ (Point-of-Service) 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®, our 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	Nonparticipating 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 Nonparticipating—based on dentist's submitted fee or Delta Dental's nonparticipating dentist fee, whichever is less.

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DELTA DENTAL

BENEFIT FEATURES FOR OPTIONAL DENTAL BENEFITS—LOW

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. Our participating PPO dentists agree to charge no more than the Delta Dental PPO fee schedule amount for covered services. Services provided by a nonparticipating dentist are not covered.

DELTA DENTAL PPO (STANDARD)

	Plan Pays*	
	Delta Dental PPO Dentist*	Nonparticipating 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.

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Customer Service (800) 971-4108 • www.deltadentalmi.com

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DELTA DENTAL

QUESTIONS AND ANSWERS ABOUT DELTA DENTAL PPO℠ (POINT OF SERVICE)—OPTIONAL DENTAL BENEFITS—HIGH & MEDIUM

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 nonparticipating 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. We will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating 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.

Do I need an ID card to receive care?

No. Your dentist can verify your eligibility for coverage 24/7 by checking our online Dental Office Toolkit® or by calling our DASI (Delta Dental's Automated Service Inquiry) system. If you would like an ID card for reference purposes, you can use our 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. Our DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims, and eligibility information, our 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 our 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 our 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

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. Our 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 our Customer Service department at (800) 971-4108. Our 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 our 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 our online Dental Office Toolkit® or by calling DASI. If you would like an ID card for reference purposes, you can use our online Consumer Toolkit® at www.deltadentalmi.com to print one.

What if I have other questions?

Please call our Customer Service department at (800) 971-4108. Our DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims, and eligibility information, our 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 our 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 our 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.

Little extras add up to big advantages for you

You'll get extra perks when going SOLO, thanks to the HAP Advantage program. Your overall health and well-being are important to us, so we've obtained special discounts on extra services ranging from fitness clubs to Weight Watchers®.

THE SOURCE FOR A BETTER YOU™
GlobalFit

Looking to achieve your total health goals? Or just want to feel better about yourself? The HAP Advantage program now offers GlobalFit. GlobalFit gives you affordable, convenient access to a full range of health living options, including flexible membership options to more than 2,000 fitness clubs nationwide, a special low price on the NutriSystem® weight-loss program, home exercise options, smoking cessation, stress reduction and more.

Just visit www.globalfit.com/HAP or call 1-800-294-1500 for more information or to find a club near you.

A HEALTHY NEW YOU
Weight Watchers®

The HAP Advantage program offers preferred rates at Weight Watchers®. Whether you like to attend weekly meetings or start an "At-Work" program at your place of employment, Weight Watchers® will offer you a great member rate.

For more information, go to www.hap.org or call 1-888-3-FLORINE (1-888-335-6746) and identify yourself as a SOLO enrollee, powered by HAP.

LASIK: SEE THINGS DIFFERENTLY
OptimEyes

Receive special discounted rates on Laser Vision Correction (LASIK) services at all area OptimEyes Centers. Call 1-800-EYE-CARE to make an appointment. No physician referral is needed. Show your SOLO ID card to receive the HAP Advantage rate.

* 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 Alliance Health and Life Insurance Company (Alliance) Health Insurance Policy. Alliance, its affiliates, agents and assigns make no representations or warranties regarding the quality, price or effectiveness of the services or products, or the credentialing of the providers, made available by HAP Advantage.

Here are some additional programs that complement your SOLO coverage. It's all part of being powered by HAP.

HOME DELIVERY PHARMACY

In addition to filling your prescriptions at a retail pharmacy, we offer **mail order prescription service through Medco Home Delivery.** The advantage of mail order prescription service is simple! You can get a 90-day supply of your medication saving time and money by eliminating monthly trips to the pharmacy. To learn more, go to www.hap.org.

HEALTH IMPROVEMENT PLANS DESIGNED FOR YOU

iStrive for better health

iStrive for better health

Need a little help getting healthy? SOLO has just the thing. iStrive for better health, a personalized health improvement program. iStrive includes a health risk assessment and six healthy lifestyle programs – all free and available online.

With the health assessment, you'll prioritize the health changes you may be ready to make in your life. Our health care professionals then use your responses to design an online plan just for you; no two plans are the same. Your plan will provide personalized strategies to help you make healthy choices, overcome pitfalls and achieve health goals.

Then, take the next step by choosing from six lifestyle behavior change programs. These easy-to-use and private online programs help you make healthy choices that last for the long run.

Best of all, you'll earn great rewards just for taking the assessment and enrolling in the programs.
For more information, visit www.hap.org and click the iStrive button.

INNOVATIVE ONLINE SERVICES

www.hap.org

With SOLO, you enroll entirely online – so why not manage your health coverage online as well?

- Use our online Provider Search tool to find providers in your area
- Change your address and, when needed, request a new ID card for yourself or your covered minor dependent(s)
- Discover information on healthy living, disease management and health education classes
- Use our award-winning Member Health Reminder application to view reminder messages for services and health screenings
- View an updated list of affiliated emergency rooms and urgent care centers
- View your eligibility and benefits
- Contact Client Services through our secure Customer Message Center
- Use our Interactive Drug Search and view your Pharmacy Claim History
- Check status of your claims
- Explore links to affiliated hospital Web sites
- View safety and quality information for HAP's affiliated hospitals from Leapfrog
- And much more

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 insurance, 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 SOLO powered by HAP 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. 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, or**
- **For other reasons permissible by law.**

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

Optional Maternity Coverage

SOLO offers a maternity coverage through a Maternity Rider for you or your spouse (if covered under the policy)

Covered charges include:

(all services are subject to deductible and co-insurance)

- Pre-natal care
- Labor and delivery
- Postpartum services
- In-hospital care of well newborns and associated all charges

When can the Maternity Rider be purchased?

At time of the initial Application or at your policy's renewal date. The female applicant who purchases the Maternity Rider is subject to medical underwriting. The Maternity Rider is only offered to one female applicant per policy.

Can the Maternity Rider be added if previously dropped?

If you drop the Maternity Rider, it cannot be purchased again

When can I drop the Maternity Rider?

Once a year on the policy's renewal date

What is the waiting period until benefits are payable?

- The coverage must be in force for a minimum of 12 months before the delivery date
- You cannot be pregnant at time the rider is requested
- You cannot buy coverage if cognitive of pregnancy
- The Policy covers maternity-related claims for deliveries 12 or more months after the effective date of coverage
- Claims paid for pre-delivery services will not be considered or paid until after the delivery occurs.

How do I get coverage for my newborn?

Just contact us at SOLO@hap.org within 31 days from the birth of your child and include the following:

- Child's Date of Birth
- Gender
- Social Security Number (if available)
- Mother's Alliance Number
- If you notify us after 31 days from the birth of your child, go to www.hap.org to apply for SOLO coverage for your newborn.

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. Pregnancy, pregnancy related-prescriptions and well-baby expenses.
4. 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.
5. Sex-change procedures.
6. Cosmetic services.
7. Weight-loss programs and services.
8. Experimental and investigational services.
9. Eye care and vision services (routine eye exams are covered).
10. Foot care.
11. Mental health and chemical dependency – in excess of the maximum benefit, custodial care, marriage counseling, phone consultations, etc.
12. Nursing services – private duty nursing services, residential and basic nursing services provided in a long-term care facility.
13. Oral, maxillofacial and dentistry services.
14. Dietary drugs, food and food supplements.
15. Therapy and rehabilitation services –- beyond the authorized visit limit as approved by Alliance, genetic testing, premarital exams, classes, or marriage counseling, etc.
16. 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.
17. 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.
18. Services required by a third party.
19. 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.
20. 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 www.hap.org/info/privacy.php

Health Coverage for Individuals and Families

www.hap.org/SOLO

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