



Discover the Plan That's Just for You

Individual and family plans





Greetings from HAP

Selecting a health plan for yourself or your family is a big decision. You want to make sure you're covered, that you can keep seeing your doctors, that your prescriptions won't be affected. You have questions and you want to know that your health plan will have answers. At HAP, we are committed to great coverage that is easy for you to use. We hope this guide will answer all your questions about becoming a HAP member. But if it doesn't, please feel free to call us at **(855) WITH-HAP (948-4427) (TTY: 711)**.

Table of Contents

Why Choose HAP	6
Quality coverage.....	7
Real people	7
Protecting your time, money and peace of mind	7
Health Care Cost Estimator	7
24/7 online doctor visits	8
Emergency services and urgent care	8
Students Away at School	8
Support on your health care journey	9
iStrive for Better Health	9
Member extras.....	9
Restore programs	10
HAP Coverage Area and Networks	11
Coverage Area Map.....	12
Henry Ford Choice Network	14
Genesys Choice Network	16
HAP Plans	18
Understanding Cost Sharing	19
How you share in the costs of your health plan.....	20
What is cost sharing?.....	20
Copay	20
Deductible	20
Coinsurance	20
Out-of-pocket limit.....	20
A cost-sharing example	21
How does it all work together?	23
More about deductibles	24
Family out-of-pocket limit	25
Cost Sharing for Qualified High-Deductible Health Plans.....	26
Health Savings Accounts for Individuals and Families	27
Save on health care costs without compromising coverage.....	27
The benefits of an HSA plan	27
Examples of qualified and nonqualified expenses	28
Prescription Drug Coverage.....	29
Tier classes.....	29
Additional coverage	29
Tiers at a glance	30
Mail order and specialty provider services	30
Dental Coverage at a Glance for Individuals and Families	31
Vision Coverage at a Glance	34
What to know before you enroll	35

What is open enrollment?	35
When is the open enrollment for 2019 coverage?	35
What's a special enrollment period?.....	35
Can I be denied coverage?	35
Am I eligible for Medicare or Medicaid?	36
What do I need to do before I can enroll?.....	36
Once You're a HAP Member	37
Getting started	38
Quick and easy access	39
Online account management.....	39
Online doctor visits 24/7	40
Mobile apps	41
Managing your HAP plan.....	43
Pay your bill online	43
Receive paper invoices	43
Payment and delinquency process.....	44
Cancellation of coverage	45
Precertification.....	45



Why Choose HAP?



Why Choose HAP?

Your health care plan isn't just for emergencies. It should support your health each and every day.

HAP does just that. We offer benefits, programs and services that other health plans don't have. And, when you need support, we're here.

Your health care needs are individual and personal. And so is the service you get from HAP.

Quality coverage

When it comes to quality health care, we have you covered. We offer a variety of plans because health care isn't one-size-fits-all. Let us help you find a plan to fit your needs and budget. Expert HAP representatives are waiting to help you pick the perfect one for you.

Please call **(855) WITH-HAP (948-4427) (TTY: 711)**
for help selecting a HAP plan.

Real people

To make it easy to use your new HAP health care plan, we have a team of personal service coordinators to help you get started. When you enroll, a coordinator will call to welcome you and explain your benefits. They'll also tell you how our programs and services can keep you healthy and save you money. We're real people. And we're here to answer your questions, provide guidance and take care of your concerns.

Protecting your time, money and peace of mind

Your health and well-being depend on getting the care you need. We help you get it quickly, wherever you need it and at the lowest cost to you. Our Health Care Cost Estimator, online doctor visits and around-the-world emergency care are just a few ways we make your health care easy, affordable and worry-free.

Health Care Cost Estimator

Treatment costs vary widely among doctors and facilities. Knowing the costs before you get care can help you choose providers. Use HAP's simple online Health Care Cost Estimator to estimate your costs for doctor visits and procedures. You can search by treatment type or medical condition and compare costs among doctors and facilities.

24/7 online doctor visits

Talk to a doctor any time of the day or night wherever you are. HAP's telehealth partner American Well® gives you easy, affordable access to licensed, board-certified doctors 24/7 on a secure site. They can help you with nonemergency medical issues and prescriptions. You can use this service online or by mobile app.

Emergency services and urgent care

When you're hurt or sick, you need fast, no-hassle care. With HAP, no matter where you are, you're covered for:

- **Emergencies:** For a severe medical emergency, such as a broken bone, chest pains, difficulty breathing or a severe burn, you're covered. You can go to any emergency room, anywhere in the world.
- **Urgent care:** An urgent care center may be faster and less costly than an emergency room. For health issues that are not life-threatening, you can go to any HAP-affiliated urgent care center in Michigan. They're equipped to handle issues such as sprains, cuts that need stitches, minor burns, back pain, the flu and more.
- **CVS Minute Clinics:** HAP members can access convenient care at CVS Minute Clinics. Their nurse practitioners and physician assistants can help with nonemergency conditions and prescriptions. Minute Clinics are open seven days a week, including nights and weekends. No appointment is needed, and the cost is the same as a PCP office visit.
- **Travel assistance:** For travel emergencies, HAP members have 24/7 access to Assist America. Their expert call center staff can help you find a doctor or hospital; get transportation; and replace prescriptions, lost luggage or documents and more. It's available when you're more than 100 miles from home or in another country. Assist America also provides free identity theft protection.

Students Away at School

If you have kids away at school, you want them to get health care when they need it. HAP covers students with HMO coverage for medical emergencies and urgent care. And – with prior approval – they can get services such as, flu shots, allergy injections, covered prescriptions and some services for managing chronic conditions.

For more information,
visit hap.org/studentsaway.

Support on your health care journey

From award-winning wellness programs to care management, we'll support you in getting and staying healthy.

iStrive® for Better Health

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

Member extras

HAP offers a variety of health and wellness discounts. We can help you with gym memberships, weight loss programs and more. We also have many online tools and resources. Check out our member website, **hap.org**, HAPOnTheGo mobile app and our Balanced Living blog, which you can find at **hap.org/balancedlivingblog**.



Restore programs

Chronic and complex conditions can be hard to manage. They can require multiple health care providers, prescriptions, appointments and treatments. The following Restore programs help take care of medical concerns so you can take care of you:

Restore CareTrack®

Chronic conditions can present you with health and lifestyle challenges. Our goal is to give you the tools to manage them. HAP's CareTrack nurses provide one-on-one coaching to help you make smart choices and learn to manage your condition. The program focuses on conditions such as asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes and heart failure. Through CareTrack, you can also talk with behavioral health specialists and pharmacists for help with emotional, behavioral and medication issues.

Restore Care Management program

Restore Care Management is a free program for HAP members with complex conditions and those transitioning between care settings. A registered nurse works closely with you and your doctor to get you the right care. And they can help remove any barriers to getting the services you need. This may include help with medications, equipment, supplies, appointments, tests, therapy, home visits and community resources. We want to help avoid return trips to the emergency room or hospital.

Restore Comfort and Palliative Care

The Restore Comfort and Palliative Care program is a prehospital care program. It provides 24/7 support for members managing end-stage illnesses or conditions. The goal is to increase comfort and reduce unnecessary emergency room visits and hospitalizations. It provides in-home health care services with both curative and palliative treatment options. And, when appropriate, the program helps with transition care to hospice services.

Let us make health care easy for you

From our personal service coordinators, to the leading doctors and hospitals we work with, to all the extra benefits we include in our plans, our members are at the heart of all that we do.

Please visit hap.org/plans or call a HAP representative at **(855) WITH-HAP (948-4427) (TTY: 711)** to learn more.

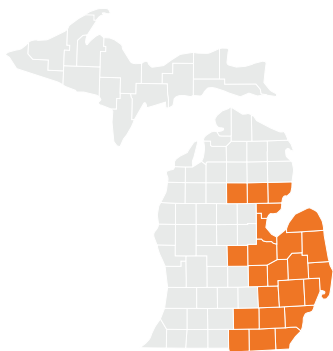
A photograph of a man and a young girl playing in a room. The man, wearing a blue denim shirt and olive green pants, is standing and reaching out with his hands above the girl's head. The girl, wearing a blue denim vest over a white shirt and dark leggings, is jumping or running towards him. They are in a room with a large window in the background and a white cabinet with multiple drawers on the right. The floor is covered with a light-colored rug. The text "HAP Coverage Area and Networks" is overlaid on the left side of the image in an orange font.

HAP Coverage Area and Networks



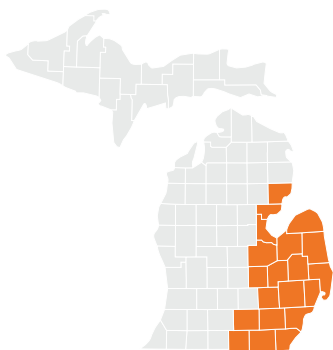
HMO and PPO coverage

PPO coverage



PPO network – 23 counties

A PPO offers members the most choice and flexibility. They must reside in the network, but don't need to select a PCP. They can seek care within or outside of the network without referrals. This type of health plan offers a wide range of benefit options. This includes incentives such as reduced out-of-pocket costs if members get care from network providers. HAP Individual and family offers several PPO health plans with varying deductibles to fit any budget.



HMO network – 20 counties

HMO plans tend to be more affordable. Members need to select a PCP from an established network of providers who'll manage and track their health care services. When they need to see a specialist, their PCP will coordinate care.



Henry Ford Choice network

HMO members must reside and seek care in Macomb, Oakland* and Wayne counties.



Genesys Choice network

HMO members must reside and seek care in Genesee County.

*Excludes the following ZIP codes in Oakland County: 48346, 48348, 48350, 48353, 48356, 48357, 48359, 48360, 48362, 48367, 48370, 48371, 48428, 48430, 48439, 48442, 48455, 48462

Coverage in Lenawee County will be effective Jan. 1, 2019, pending state approval.

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

©2018 HAP – a nonprofit company



Henry Ford Choice Network

A better choice in health care savings

The Henry Ford Choice network offers outstanding care from a health system known for its clinical excellence and medical research. You can choose from a select group of doctors and other health care providers within the Henry Ford Health System. You'll also enjoy lower monthly premiums and still receive the same quality care you expect from any HAP-affiliated provider.

A single dedicated network

The Henry Ford Choice network is for residents and small businesses in Macomb, Oakland and Wayne counties.¹ It includes nearly 5,000 doctors. Because these doctors are affiliated with the Henry Ford Physician Network, it's easier for your primary care physician to coordinate your care with other doctors.

If you and your PCP decide you need specialty care, your PCP will refer you to a specialist in the Henry Ford Physician Network. In extreme situations (for example, a doctor who meets your specific needs but isn't part of the Henry Ford Physician Network), your PCP will work with HAP to obtain a referral for a specialist from C.S. Mott Children's Hospital or University of Michigan Hospital.²

Health care at your fingertips

Henry Ford provides convenient and affordable care in ways that go beyond those offered by traditional health care providers.

Through the online portal MyChart, you can securely manage and receive information about your health. Check test results, view and send messages to your doctor, initiate an online e-visit, schedule an appointment, renew prescriptions and more. You can access:

- **Telehealth:** Now you can connect with a doctor 24/7 using your mobile phone, tablet or computer thanks to HAP's partnership with American Well®.
- **Online e-visits:** Through your Henry Ford MyChart account, you can initiate an e-visit with your doctor for nonurgent medical concerns. Answer a series of online questions about your symptoms, and your doctor will send you a message with a diagnosis and treatment within one business day (in some cases the doctor may ask to see you in person).

Save on monthly premiums

Working with doctors from a Choice network allows us to lower costs. This means your monthly premiums could be lower than our full HMO network. Because your doctors work closely with others in the same network, we can cut down on unnecessary expenses. All of your medical records are in one place, too.

A wide range of care options

The Henry Ford Choice network includes doctors and specialists from the Henry Ford Physician Network. Hospitals in this network include:

- Henry Ford Hospital
- Henry Ford Kingswood Hospital (behavioral health)
- Henry Ford Macomb Hospital – Clinton Township
- Henry Ford Macomb Hospital – Mount Clemens (behavioral health)
- Henry Ford West Bloomfield Hospital
- Henry Ford Wyandotte Hospital

Emergency and urgent care

With all HAP health plans, you can go to any hospital for an emergency. If you have a medical situation that is not life-threatening, go to a Henry Ford Choice network walk-in clinic or urgent care center. These clinics are staffed by doctors and nurse practitioners to help adults and children with minor fractures, sprains, flu symptoms, back pain and more.

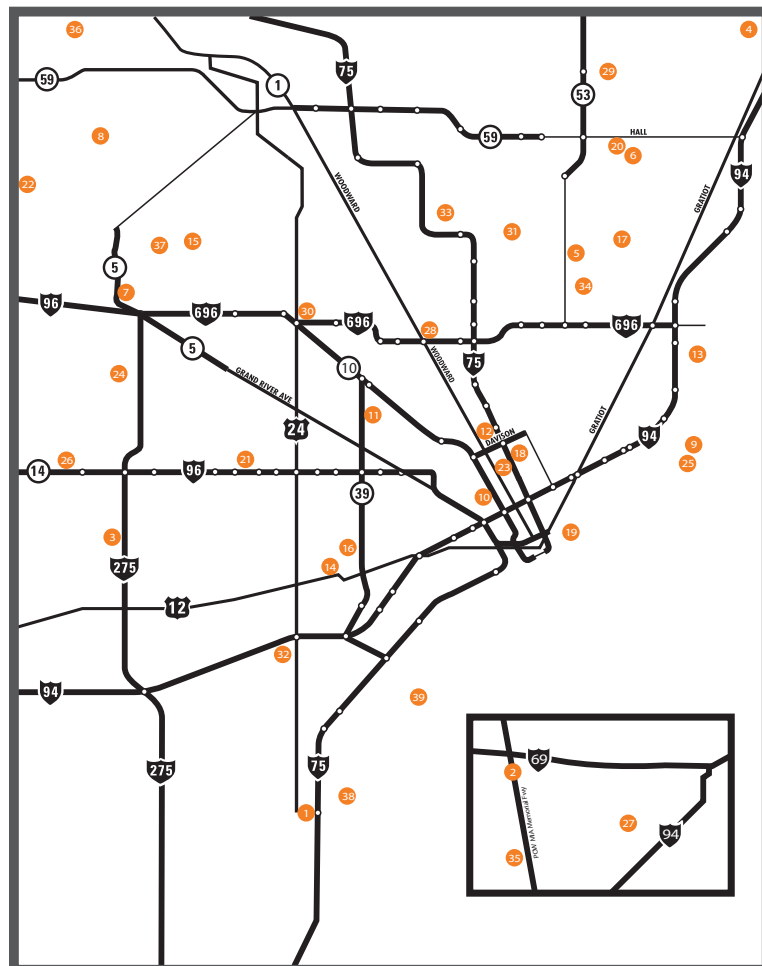
For more information about the Henry Ford Choice network, visit hap.org/hfcpcp

¹Henry Ford Choice excludes these ZIP codes in Oakland County: 48346, 48348, 48350, 48353, 48356, 48357, 48359, 48360, 48362, 48367, 48370, 48371, 48428, 48430, 48439, 48442, 48455 and 48462.

²HAP reserves the right to modify the specialist providers participating in the Choice program.

Henry Ford Choice network facilities

For a full list of Henry Ford Choice network doctors, walk-in clinics and other providers, visit hap.org/hfcpccp.



You can select your primary care physician from our large network of Henry Ford Choice network doctors.

To find a PCP in the Henry Ford Choice network, visit hap.org/hfcpccp.

Some PCPs are in private offices, while others work out of medical centers found on this map. Not all doctors in these facilities are part of the Henry Ford Choice network. It's important to check if a doctor accepts your coverage before you make an appointment.

Henry Ford Allegiance Health is not affiliated or included as a participating provider under Henry Ford Choice network.

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

©2018 HAP – a nonprofit company



	MC	H	ER	WIC	UC
1 Brownstown	•		•		
2 Bruce Township	•				•
3 Canton	•				
4 Chesterfield	•				•
5 Chicago Road (Warren)	•				
6 Clinton Township (Henry Ford Macomb Hospital)		•	•		
7 Columbus (Novi)	•			•	
8 Commerce	•				
9 Cottage (Grosse Pointe)	•		•	•	
10 Detroit (Henry Ford Hospital)		•	•		
11 Detroit Northwest	•			•	
12 Detroit				•	
13 East Jefferson (St. Clair Shores)	•				
14 Fairlane (Dearborn)	•		•	•	
15 Farmington Road (West Bloomfield)	•				
16 Ford Road (Dearborn)	•				
17 Fraser	•				•
18 Hamtramck	•				
19 Harbortown (Detroit)	•				
20 Lakeside (Sterling Heights)	•				
21 Livonia	•				
22 Milford	•				
23 New Center One (Detroit)	•				
24 Novi	•				
25 Pierson Clinic (Grosse Pointe Farms)	•				
26 Plymouth	•				
27 Richmond	•			•	
28 Royal Oak	•				
29 Shelby Township	•				•
30 Southfield	•				
31 Sterling Heights	•		•	•	
32 Taylor	•				
33 Troy	•				
34 Warren	•				
34 Washington Township	•				
35 Waterford	•				
36 West Bloomfield Hospital		•	•		
37 Woodhaven	•				
38 Wyandotte (Henry Ford Wyandotte Hospital)		•	•		

**MC – Medical center
or health center
H – Hospital**

**ER – ER
WIC – Walk-in clinic
UC – Urgent care**



Genesys Choice Network

A better choice in health care savings

The Genesys Choice network offers outstanding care from a select group of doctors and other health care providers. You'll also enjoy lower monthly premiums and still receive the same quality care you expect from any HAP-affiliated doctor.

A single dedicated network

The Genesys network is for residents and small businesses in Genesee County. It includes more than 4,000 doctors. Because these doctors are affiliated with the Genesys Physician Hospital Organization, it's easier for your primary care physician to coordinate your care with other doctors.

If you and your PCP decide you need specialty care, your PCP will refer you to a specialist in the Genesys Physician Hospital Organization. In extreme situations (for example, a doctor who meets your specific needs, but isn't part of the Genesys Physician Hospital Organization), your PCP will work with HAP to get a referral for a specialist from C.S. Mott Children's Hospital, Henry Ford Hospital, Hurley Medical Center or University of Michigan Hospital.*

Save on monthly premiums

Working with doctors from a Choice network allows us to lower costs. This means your monthly premiums could be lower than a health plan with our full HMO network. Because your doctors work closely with others in the same network, we can cut down on unnecessary expenses. All your medical records are in one place, too.

A wide range of care options

The Genesys Choice network includes doctors and specialists from the Genesys Physician Hospital Organization. Facilities in this network include:

- Genesys Regional Medical Center
- Affiliated urgent care centers

Emergency and urgent care

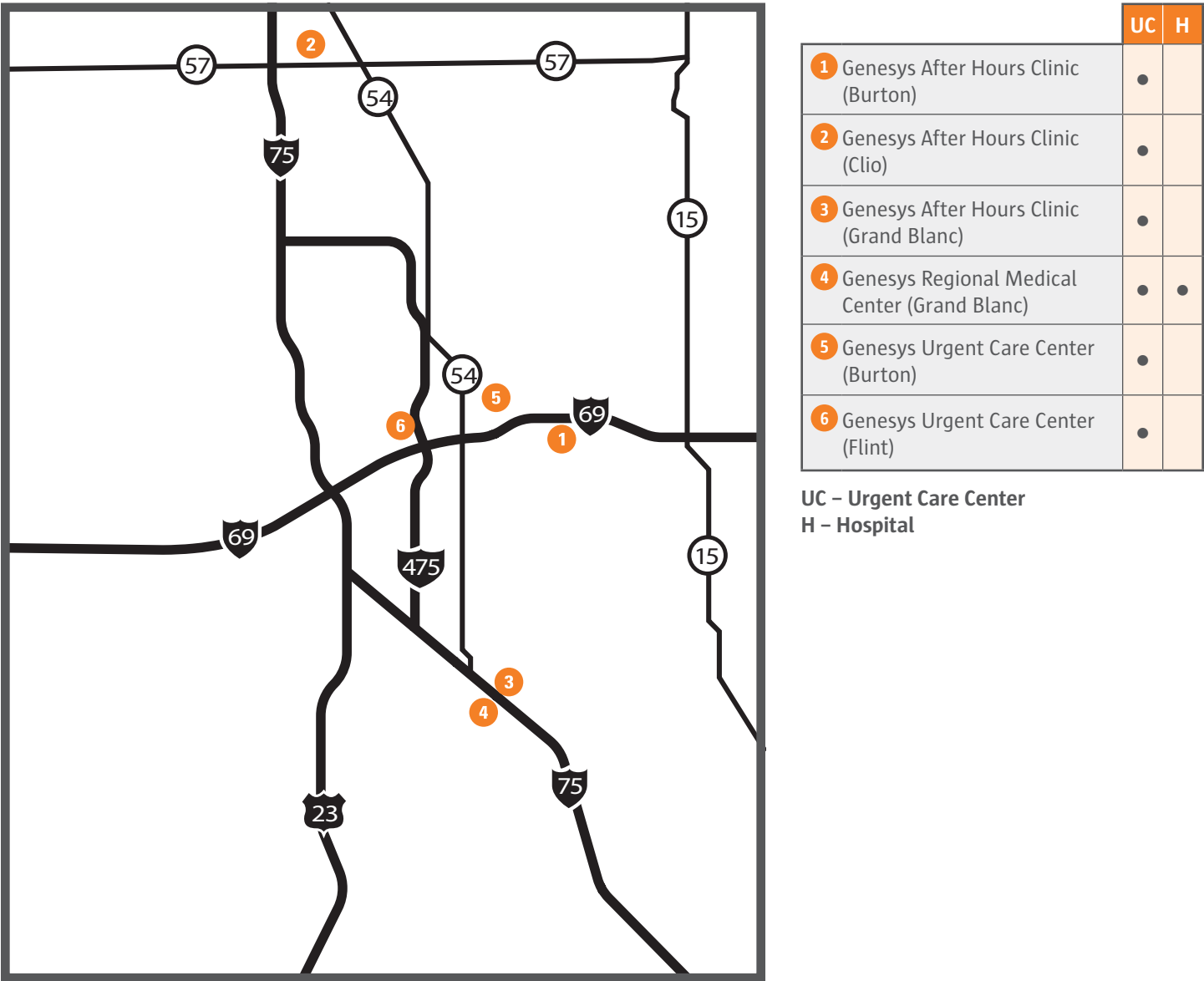
With all HAP health plans, you can go to any hospital for an emergency. If you have a medical situation that's not life-threatening while in Genesee County, go to a Genesys Choice network urgent care center or hospital.

For more information
visit hap.org/gcpcp

*HAP reserves the right to modify the specialist providers participating in the Choice program.

Genesys Choice network facilities

For a full list of Genesys Choice network doctors, urgent care centers and other providers, visit hap.org/gccpcp.



You can select your primary care physician from our large network of Genesys Choice network doctors.

To find a PCP in the Genesys Choice network, visit hap.org/gccpcp.

Some PCPs are in private offices, while others work out of Genesys Regional Medical Center. Not all doctors practicing at Genesys Regional Medical Center are part of the Genesys Choice network. It’s important to check if a doctor accepts your coverage before you make an appointment.

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

©2018 HAP – a nonprofit company

A man with a beard and glasses, wearing a light blue button-down shirt and dark blue jeans, is sitting on a green quilted sofa. He is holding a tablet computer with both hands and looking at the screen. The sofa is positioned in front of a large window with white shutters. On the light-colored wooden floor in front of the sofa, a pair of brown suede chukka shoes with white laces is placed. A semi-transparent white rounded rectangle is overlaid on the left side of the image, containing the text 'HAP Plans'.

HAP Plans



Understanding Cost Sharing



How you share in the costs of your health plan

Every health plan is unique. Your specific benefits and costs depend on which plan you choose. But, before you choose a health plan, make sure to look beyond the monthly premium to see the real costs. And you should understand what your share of those costs will be.

To learn more about your health plan's coverage, check your Summary of Benefits and Coverage. To find the SBC, visit hap.org. Members can log in and click on the *My Benefits* link.

What is cost sharing?

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



COPAY*

This is a set amount you pay each time for certain covered health care services, medications and other medical supplies. The copay amount can vary.



DEDUCTIBLE

Deductibles are the amount you owe for certain covered health care services before your health plan begins to pay for them. Your plan may include per-person deductible amounts and family deductible amounts. (See “More about deductibles” on Page 6.)



COINSURANCE

Your coinsurance is the percentage of the allowed amounts that you pay for certain covered services after your deductible has been met. Some plans don't have coinsurance.



OUT-OF-POCKET LIMIT**

Your out-of-pocket limit is the most you pay for covered services during a benefit period, usually a calendar year, before your plan begins to pay 100 percent of the allowed amount. All copays, coinsurance and deductible amounts count toward your out-of-pocket limit.

Note: These symbols are used throughout to help illustrate cost sharing.

*Copays don't count toward your deductible. You'll continue to pay copays after you've met your deductible until you reach your out-of-pocket limit. The out-of-pocket limit may not apply to grandfathered health plans.

**The out-of-pocket limit doesn't include your monthly premium or noncovered services.

A cost-sharing example

In the following scenario, Ben and his family have a health plan with a benefit period from Jan. 1 through Dec. 31.

The plan includes:

- \$35 doctor visit copay
- \$20 generic drug copay
- \$35 physical therapy copay
- \$2,000 per-person and \$4,000 family deductible
- 20 percent coinsurance
- \$4,500 per-person and \$9,000 family out-of-pocket limit

This is only an example of cost sharing. Your situation may be different.



Ben goes to his doctor for an annual checkup. The doctor asks about Ben's overall health, checks his weight and blood pressure and does other routine screenings. Ben's plan has no copay for this preventive care visit.

Later in the month, Ben hurts his shoulder in a skiing accident. Because he's in a lot of pain, Ben goes to his doctor. His plan has a **\$35 COPAY** for a primary care office visit.

Ben's doctor writes a prescription for drugs to help with the pain and swelling. Ben fills the prescription at a local pharmacy. His plan has a **\$20 COPAY** for generic drugs. That's a total of \$55 out of Ben's pocket.



Ben's shoulder pain isn't getting any better. To find out what's wrong, his doctor orders a test called an MRI. The bill for the MRI is \$1,000. Since Ben's plan has a **\$2,000 PER-PERSON DEDUCTIBLE**, he'll pay the full \$1,000 for this service. He's now halfway toward meeting his deductible.

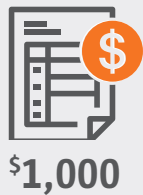


MAR

1

Ben's MRI results show that he needs shoulder surgery. The surgery will require Ben to stay in the hospital overnight. The bill for Ben's surgery and hospital stay is \$12,000. Because Ben has **\$1,000 LEFT BEFORE HE MEETS HIS DEDUCTIBLE**, he'll pay the first \$1,000 of the bill.

This leaves a balance of \$11,000. Because Ben's plan has **20 PERCENT COINSURANCE** on certain covered services, he'll pay an additional \$2,200 (20 percent of \$11,000). Ben's health plan will pay the rest of the bill (\$8,800). Ben's total cost for these services is \$3,200. He has now met his per-person deductible for the year.



= \$3,200



\$4,255 toward Ben's out-of-pocket limit

APR - JUN

1

Ben's doctor orders three months of physical therapy to help his shoulder. His plan has a **\$35 COPAY** per visit for the therapy and his doctor orders 10 visits. Until he meets his out-of-pocket limit, Ben will pay \$35 at each therapy visit.

When he began physical therapy, Ben had already paid \$4,255 toward his out-of-pocket limit of \$4,500. After paying the copay for seven visits, he'll reach his out-of-pocket limit. Once he does, his health plan will pick up the remaining allowable amounts of all covered care for the rest of the benefit period, even those unrelated to his shoulder surgery.



\$35 x 7 visits = \$245



\$4,500 toward Ben's out-of-pocket limit

OCT

1

Ben has a very sore throat and goes to the doctor. His doctor runs some tests that show Ben has strep throat. Ben's doctor writes a prescription for an antibiotic and he gets it filled at a local pharmacy. Because he has met his out-of-pocket limit, Ben doesn't pay for these services or for the prescription. Ben's health plan pays the full amount.



= \$0







\$4,500 out-of-pocket limit has been met

How does it all work together?

Copays, coinsurance and deductibles all add up to out-of-pocket limits. In our example, Ben met his out-of-pocket limit in June. This means that Ben’s health plan will pick up all the remaining allowable amounts of his covered care for the rest of his benefit period. Since Ben’s benefit period ends on Dec. 31, he doesn’t have to pay for any covered services for the rest of the year.

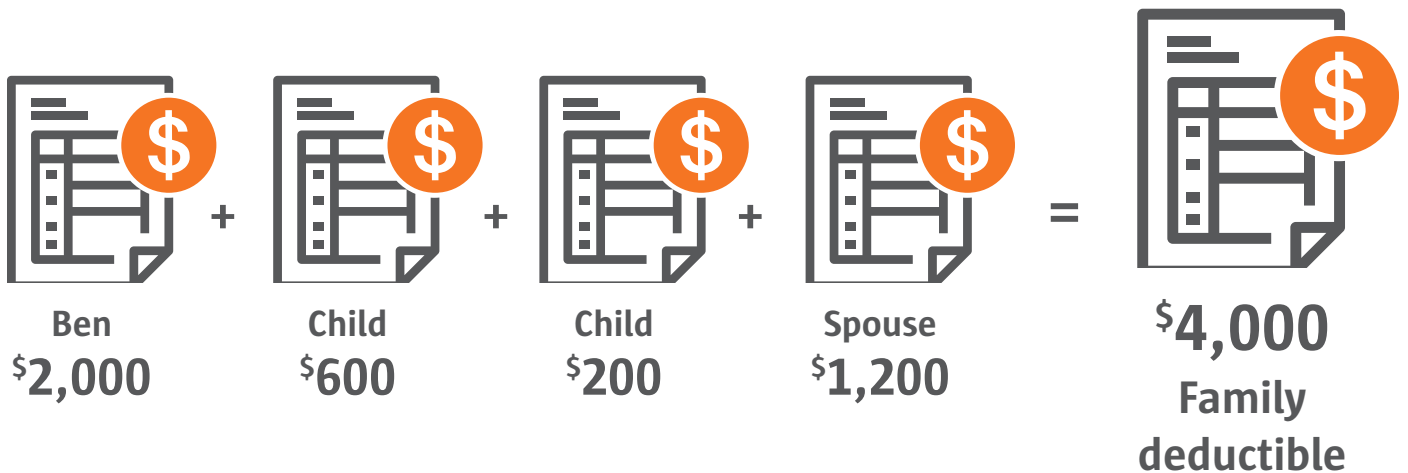
Summary of Ben’s costs:

Amount Ben has paid																		
	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.						
	Copays						<div>Out-of-pocket limit met.</div> <div>Ben’s health plan pays 100 percent of the allowable amount for all covered services.</div>											
	Doctor’s visit	\$35																
	Prescription	\$20																
	Physical therapy				\$245													
	Deductible																	
	MRI		\$1,000															
	Surgery			\$1,000														
	Coinsurance																	
	Surgery			\$2,200														
	Out-of-pocket limit (\$4,500)	\$55	\$1,000	\$3,200	\$245													
		\$4,500 total																

More about deductibles

This scenario is based on a health plan that covers Ben and his family with a \$2,000 per-person deductible and a \$4,000 family deductible.* Each person in Ben's family has a deductible. Once one family member has met the deductible, as Ben did, the health plan will pay for all covered services for that family member, even though the total family deductible hasn't been met.

It's important to note that a family can still meet its full deductible without each person meeting his or her own amount. When a family collectively meets the family deductible, all family members are considered to have met the deductible. For example, after surgery, Ben met his \$2,000 deductible. This \$2,000 would also count toward Ben's \$4,000 family deductible. Since the per-person deductible is \$2,000, Ben can only count \$2,000 of his medical costs toward the family deductible, even though he had more costs (such as copays and coinsurance) throughout the year. These other costs count toward his out-of-pocket limit. Together, the rest of Ben's family members must meet the remaining \$2,000 of their deductible.

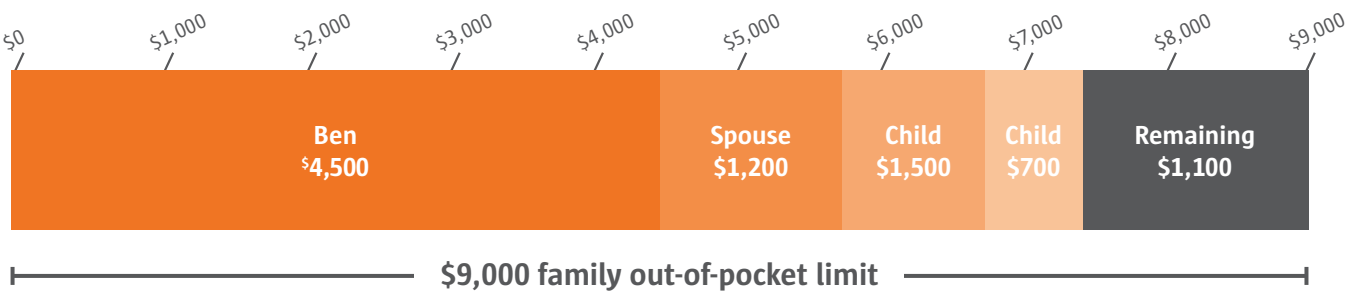


*If your plan has "HSA" in the name, you have a plan that's paired with a health savings account, called a "qualified high-deductible plan." These plans may have different types of deductibles. For more information about our HSA plans, visit hap.org.

Family out-of-pocket limit

Ben has met his \$4,500 out-of-pocket limit. This also counts toward the \$9,000 family out-of-pocket limit.

Collectively, Ben’s spouse and their two kids met the remainder of the family deductible, but not the family out-of-pocket limit. His family continues to pay copays and coinsurance until they meet that limit.



For more information about our health plans, please visit hap.org.



Cost Sharing for Qualified High-Deductible Health Plans

Our qualified high-deductible health plans for families have two types of deductibles: aggregate and aggregate with a cap. Both options can be paired with a health savings account. In each case, all family members on the plan work together to meet the family deductible. The following chart explains the differences:

Deductible type	Example	How it works
Aggregate	Self-only deductible: \$2,000 Family deductible: \$4,000 (Out-of-pocket limit amounts vary based on each specific plan.)	When one person in the family meets the family deductible or when the whole family collectively meets the deductible, all members are considered to have met the deductible.
Aggregate with a cap	Self-only deductible: \$5,000 Family deductible: \$10,000 Self-only out-of-pocket limit: \$6,000 Family out-of-pocket limit: \$12,000	The most any one person in the family will pay toward the family deductible is the self-only out-of-pocket limit. Once a family member meets that amount, HAP pays the entire allowed amount for all covered services in the benefit period for that family member. Once the family collectively meets the family deductible, all family members are considered to have met the deductible.

Out-of-pocket limits

The two types of out-of-pocket limits are:

1. **Aggregate.** When either one person in the family or the entire family meets the family out-of-pocket limit, HAP will begin to pay the entire allowed amount for covered services for everyone on the policy during the benefit period.
2. **Embedded.** The self-only out-of-pocket limit is included, or embedded, in the family out-of-pocket limit. This means that when one person in the family meets the individual out-of-pocket limit, HAP will begin to pay the entire allowed amount for all covered services for that person during the benefit period. Once the whole family meets the family out-of-pocket limit, HAP will begin to pay the entire allowed amount for all covered services for the entire family during the benefit period.

For more information, please contact your HAP representative.

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

©2018 HAP – a nonprofit company



Health Savings Accounts for Individuals and Families

Save on health care costs without compromising coverage

A qualified high-deductible health plan paired with a health savings account is a tax-free way to save money on certain out-of-pocket health care costs. The money in an HSA can be used to pay for out-of-pocket costs such as coinsurance, deductibles and copays. This can include costs for medical, prescription drug, dental and vision services and more.

HAP offers a variety of qualified high-deductible health plans to pair with an HSA. Together, they can help you save for future health care expenses. Funds over \$1,000 can even be invested in various mutual funds.

Our trusted partner BenefitWallet™ is one of the leading HSA administrators in the U.S. and can help you invest your funds. You can also open an account at another bank or credit union. Examples of qualified expenses are listed on the back of this page.

The benefits of an HSA plan

Our HSA plans provide you with savings while giving quality health coverage. Here are some of the benefits these plans offer:

- Tax-free dollars spent on qualified medical expenses
- Tax-free contributions
- Tax-free accumulated account interest

- Easy to open an account
- Funds roll over from year to year
- Two free debit cards
- Free initial book of checks
- More than 20 investment options for future growth
- Dedicated customer support and 24/7 internet and mobile access

The IRS limits the amount individuals and families can contribute to an HSA each year. For 2019, the limits are \$3,500 for an individual and \$7,000 for a family.

For more information, visit **IRS.gov** and search for health savings accounts.

BenefitWallet's highly competitive HSA fees

Account setup fee	None
Account maintenance fee*	\$3.50 per account per month

After you enroll, BenefitWallet will send you a welcome kit within seven to 10 days. Your kit will include all the instructions you need, including how to activate your HSA account.

For more information, contact your agent or call **(855) WITH-HAP (948-4427) (TTY: 711)**. We're available Monday through Friday from 8 a.m. to 6 p.m.

*Fee only applies if the average monthly balance is under \$1,000.

Examples of qualified and nonqualified expenses

The IRS determines which expenses qualify for reimbursement.

Examples of qualified expenses

- Acupuncture
- Alcohol and drug addiction treatment
- Breast reconstruction surgery
- Dental treatment
- Diagnostic tests and services
- Doctor visits
- Prescriptions
- Eyeglasses, contact lenses and exams
- Fertility enhancements
- Hearing aids and batteries
- Operations or surgery (not cosmetic)
- Nursing services
- Physical therapy
- Psychiatric therapy
- Psychiatric care
- Smoking cessation

Examples of nonqualified expenses

If you use your HSA to pay for nonqualified expenses, you'll have to pay income taxes on those funds. You'll also be assessed for a 20 percent penalty. The following are examples of nonqualified expenses.

- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Funeral expenses
- Health club dues
- Illegal operations and treatments
- Maternity clothes
- Nutritional supplements
- Over-the-counter medicines for which you do not have a doctor's prescription
- Toiletries (for example, toothbrush, toothpaste)
- Teeth whitening
- Weight loss programs

For a complete list of qualified and nonqualified expenses, visit **IRS.gov** and search for Publication 502.

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

©2018 HAP – a nonprofit company



Prescription Drug Coverage

With HAP prescription drug coverage, our goal is to make sure you get the highest quality medications at the lowest possible cost. HAP provides a list of covered drugs, known as a formulary.

Drug finder tool

Use our drug finder tool to search for drugs that HAP covers. Go to hap.org/prescriptions. Click on *Search 2019 QHP drugs*.

You can search for a drug by:

- The first letter of the drug's name
- The full name (brand or generic)
- Therapeutic class (what the drug is used for)

Or, you can download a PDF list of all drugs that HAP covers. For each drug listed, you'll see the brand name, generic name (if available), therapeutic class, dose and strength, out-of-pocket cost level (tier) and any limits or requirements that may apply.

Coverage requirements and limits

Some covered drugs have requirements or limits. These requirements are listed on the formulary and may include:

- **Prior authorization:** For some drugs, you'll need to get approval from HAP before your prescription is filled.
- **Step therapy:** In some cases, HAP may require you to first try a certain drug to treat your condition before another drug is covered.
- **Quantity limits:** Certain drugs have quantity limits.
- **Pharmacies:** Prescriptions must be filled at HAP-contracted pharmacies. To find one, visit hap.org/prescriptions. Click on *Browse pharmacies* at the top of the page.

Copay tiers

A tier determines how much your medication will cost. Here's a description of each tier:

- **Tier 1 drugs (preferred generic):** These generic drugs have the same active ingredients and strength as brand-name drugs, with the lowest copay.
- **Tier 1A drugs (nonpreferred generic):** These generic drugs have the same active ingredients and strength as brand-name drugs with a higher copay than preferred generic drugs.
- **Tier 2 drugs (preferred brand):** These brand-name drugs are designated by HAP as preferred brands. They meet the quality, safety and cost standards that are consistent with our benefit, referral and practice policies.
- **Tier 3 drugs (nonpreferred brand):** These brand-name drugs are designated by HAP as nonpreferred drugs, with a higher copay than preferred brand drugs.
- **Tier 4 drugs (preferred specialty):** These drugs are designated by HAP as specialty drugs. They're used to treat complex and chronic illnesses. They require close supervision. They may be injected, infused, inhaled or taken by mouth. They require prior authorization from HAP. To ensure safety and quality care, these drugs must be filled at a HAP-contracted specialty pharmacy.
- **Tier 4A drugs (nonpreferred specialty):** These drugs are designated by HAP as specialty drugs. They have a higher copay than preferred specialty drugs. They're used to treat complex and chronic illnesses. They require close supervision. They may be injected, infused, inhaled or taken by mouth. They require prior authorization from HAP. To ensure safety and quality care, these drugs must be filled at a HAP-contracted specialty pharmacy.

Tiers at a glance

Description of tier	Tier class
Preferred generic	Tier 1
Nonpreferred generic	Tier 1A
Preferred brand	Tier 2
Nonpreferred brand	Tier 3
Preferred specialty	Tier 4
Nonpreferred specialty	Tier 4A
Affordable Care Act preventive	No copay or other out-of-pocket costs
Medical drugs	Covered under your plan's medical coinsurance

Note: The out-of-pocket costs for each tier class depends on your prescription drug benefit. Refer to your Summary of Benefits and Coverage for more details about your drug costs.

Preventive and medical drug coverage

- **Affordable Care Act preventive:** These are drugs used to prevent illnesses, diseases or other health problems. HAP covers the generic version of these drugs without charging you a copay or other out-of-pocket costs.
- **Medical drugs:** Drugs infused or given in a doctor's office or facility that are covered under your medical benefit. Some medical drugs are classified as specialty drugs, and we may require you to get them from a specialty pharmacy.

Mail-order service and specialty provider service

HAP offers mail-order pharmacy services through Pharmacy Advantage. You can get up to a 90-day supply of some medications (new prescriptions or refill). This saves time and money and eliminates trips to the pharmacy. HAP offers specialty pharmacy services through Pharmacy Advantage, our contracted specialty provider. You must fill your specialty medications through Pharmacy Advantage.



To learn more about HAP's prescription drug coverage, visit hap.org/prescriptions.

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

©2018 HAP – a nonprofit company



Dental Coverage at a Glance

Individuals and families

When you select a HAP health plan, you can add high-quality dental coverage through our partnership with Delta Dental. You have two coverage options:

- **Pediatric-only:** If you have children age 18 or younger, you must have pediatric coverage. It's an essential health benefit under the Affordable Care Act.
- **Adult coverage:** This is for all adults age 19 and older on your health plan. It includes pediatric dental coverage for children age 18 and under. Adults without children will not be charged the pediatric plan premium. Any children on your plan will automatically convert to the adult plan and rate on Jan. 1 of the year following the child's 19th birthday.

You can purchase pediatric dental coverage elsewhere. Please note that we don't offer adult dental coverage if you purchase a pediatric plan elsewhere.

2019 dental plan rates:


- **Pediatric** – \$26.72 per child per month up to the three oldest children (the fourth and up are free)
- **Adult** – \$28.80 per adult per month

For more information on dental benefits and to search for affiliated dentists, please visit **deltadentalmi.com**.

If you have any questions, please call Delta Dental Customer Service at **(800) 971-4108** (mention HAP group #2195).

2019 Delta Dental pediatric benefits

Pediatric dental is an essential health benefit under the Affordable Care Act and is required for all members age 18 and under with a HAP health plan. For pediatric-only dental plans, a child's coverage will stop at the end of the year he or she turns 19. If you select adult dental coverage, the child's benefit will automatically convert to the adult plan and associated premium on Jan. 1 of the year following the child's 19th birthday.

Pediatric dental			
	In network		Out of network
	Delta Dental PPO SM	Delta Dental Premier [®]	Nonparticipating dentist
	Plan pays	Plan pays	Plan pays
DIAGNOSTIC AND PREVENTIVE SERVICES			
Diagnostic and preventive services – exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush biopsy – oral cancer detection	100%	80%	80%
Emergency palliative treatment – temporary pain relief	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Sealants – to prevent decay of permanent teeth	100%	80%	80%
BASIC SERVICES			
Minor restorative services – fillings and crown repair	50%	50%	50%
Major restorative services – crowns	50%	50%	50%
Oral surgery services – extractions and dental surgery	50%	50%	50%
Endodontic services – root canals	50%	50%	50%
Periodontic services – gum disease treatment	50%	50%	50%
Relines and repairs – bridges and dentures	50%	50%	50%
Other basic services – miscellaneous	50%	50%	50%
MAJOR SERVICES			
Prosthodontic services – bridges and dentures	50%	50%	50%
OUT-OF-POCKET MAXIMUM AND DEDUCTIBLE			
Out-of-pocket maximum	\$350 per eligible member or \$700 per family		
Deductible (does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, brush biopsy or sealants)	Limited to a maximum deductible of \$75 per family per benefit year		

Note: The benefits in this chart are for pediatric dental care only. It's an essential health benefit under the Affordable Care Act. Adult dental benefits are listed on a separate chart.

In-network annual out-of-pocket maximum: This is the most you or an eligible dependent will pay for covered pediatric dental care. The max amount when your coverage includes one member under age 19 will be \$350 per benefit year on all in-network covered services and \$700 for two or more members under age 19. Coinsurance, copayments, and deductibles paid for in-network covered services count toward the out-of-pocket max. Payments that do not count toward your in-network out-of-pocket max include premiums; noncovered services; out-of-network dentists; and coinsurance, copayments, or deductibles for nonpediatric dental care. It also does not include coinsurance, copayments, or deductibles for covered services for members age 19 and older.

Once you reach your out-of-pocket max for the year, in-network covered services for members under 19 will be covered at 100 percent of Delta Dental's maximum approved fee.

Out-of-network out-of-pocket maximum: There is no annual out-of-pocket max for out-of-network covered services. You must pay all coinsurance, copayments, deductibles and bills for out-of-network covered services you or your eligible dependents receive.

Annual and lifetime maximum payments: There are no annual or lifetime maximum payments for covered services for members under 19.


Waiting period: There is no waiting period for members under 19 seeking covered services.

This document is meant to supplement your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to them for costs and coverage details. They also contain policy exclusions and limitations. Or call us at the number listed in this brochure.

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

2019 Delta Dental adult benefits

When you purchase an adult dental plan, all eligible dependents age 18 and over must be covered. Adults without children under age 19 will not be charged a pediatric plan premium. Delta Dental will provide them with proof that they comply with the pediatric coverage requirement. For those with children, only the three oldest children age 18 and under are charged the pediatric rate. If you purchase pediatric coverage elsewhere, adult-only coverage is not available.

Adult dental			
	In network		Out of network
	Delta Dental PPO	Delta Dental Premier	Nonparticipating dentist
	Plan pays	Plan pays	Plan pays
DIAGNOSTIC AND PREVENTIVE SERVICES			
Diagnostic and preventive services – exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush biopsy – oral cancer detection	100%	80%	80%
Emergency palliative treatment – temporary pain relief	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
BASIC SERVICES			
Minor restorative services – fillings and crown repair	50%	50%	50%
Major restorative services – crowns	50%	50%	50%
Oral surgery services – extractions and dental surgery	50%	50%	50%
Endodontic services – root canals	50%	50%	50%
Periodontic services – gum disease treatment	50%	50%	50%
Relines and repairs – bridges and dentures	50%	50%	50%
Other basic services – miscellaneous	50%	50%	50%
MAJOR SERVICES			
Prosthodontic services – bridges, implants and dentures	50%	50%	50%
MAXIMUM PAYMENT AND DEDUCTIBLE			
Maximum payment per benefit year	\$1,000 per individual per benefit year		
Deductible (does not apply to diagnostic and preventive services, brush biopsy and emergency palliative treatment)	Limited to a maximum deductible of \$75 per family per benefit year		

Note: This chart and the benefits listed here are for adult dental care only. Pediatric dental benefits are listed on a separate chart. But they are included in all adult dental plans.

Annual and lifetime maximum payments: The maximum payment is \$1,000 total per person per benefit year. This applies to all services for members age 19 or older. It also applies to covered services that are not essential health benefits for members under age 19.

Out-of-pocket maximum payment: This is the most you or your eligible dependents will pay for covered services in one benefit year. This plan does not have an out-of-pocket max. You have to pay all coinsurance, copayments, deductibles and bills for all covered services you or your eligible dependents receive.

Waiting period: There are no waiting periods for covered services under this plan.

Eligibility: You, your spouse and your children under age 26 are eligible for this policy. This includes your children who are married, don't live with you, aren't permanently disabled or aren't your dependents for federal income tax purposes.

Anyone who chooses this dental plan must stay enrolled for 12 months. If a member drops coverage after that time, they may not re-enroll until 12 months after dropping coverage.

Benefits will end on the last day of the month for which the premium is paid.

This document is meant to supplement your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to them for costs and coverage details, including exclusions and limitations. Or call us at the number listed in this brochure.

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



Vision Coverage at a Glance

We're proud to offer our members top-notch coverage for eye care. All HAP plans include an annual eye exam – at no additional cost – from a vast network of eye care professionals. These include:

- Henry Ford OptimEyes
- SVS Vision Optical Centers
- Family Eye Care Associates
- Fraser Optical
- General Optical
- Northwest Eye Physicians, P.C.
- Rx Optical
- Andersen Eye Associates

A complete list of eye care professionals in our network is available at hap.org/doctors.

Qualified health plan coverage for small employer groups and individuals

All members 18 years of age or under can receive a pair of “collection” eyeglasses or contacts once every benefit period. Coverage remains in effect until the end of the year in which the member turns 19. Collection eyeglasses and contacts are those covered under the member’s plan. The benefit includes single vision, conventional (lined) bifocal or trifocal lenses and lenticular lenses without out-of-pocket costs. The following are also covered in the plan:

- Glass, plastic or polycarbonate lenses
- Fashion and gradient tinting
- Oversized lenses
- Scratch-resistant coating
- Glass-grey #3 sunglasses (prescription only)

Benefits for collection frames or contacts are available once every benefit period, even without a change in prescription. There’s a wide selection of frames and contacts to choose from.

Coverage for large employer groups

Coverage for eyeglasses includes collection frames and either glass or plastic lenses that meet the standards of the American National Standards Institute. This includes tinted lenses equal to pink tints #1 and #2. Collection contacts are covered in place of eyeglasses. Eyeglasses or contacts are covered once during a consecutive 12-month period.

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

©2018 HAP – a nonprofit company



What to Know Before You Enroll

Choosing a health plan is important. But it can also be confusing. We've prepared this FAQ to help cut through the confusion so you'll feel confident and prepared when it comes time to enroll. If you have questions, please call us at **(855) WITH-HAP (948-4427)**.

What is open enrollment?

It's the annual period when you can apply or change health plans.

When is the open enrollment for 2019 coverage?

The 2019 open enrollment period is Nov. 1 to Dec. 15, 2018. You can apply or change health plans only during the open enrollment period each year unless you qualify for a special enrollment period.

What's a special enrollment period?

Certain life events may qualify you to change your current health plan or sign up for a new one outside of open enrollment. This is called a special enrollment period. If you qualify for a special enrollment period, you have up to 60 days after the event to enroll or change your plan.

Qualifying life events include, but aren't limited to:

- Changes in family size (if you marry, divorce or have a baby, etc.)
- Moving to a new area
- Noncalendar year policy renewal
- Loss of coverage due to job loss, loss of group health coverage, divorce, death, aging off a parent's plan or losing Medicaid or Children's Health Insurance Program coverage

- COBRA coverage ending

Visit **hap.org/sep** for a list of qualifying life events.

Special enrollment periods can occur year-round. You can apply for one during or outside of the open enrollment period. Proof of the qualifying event (such as a birth certificate or marriage license) is required. To apply for a special enrollment period, talk to your agent, call a HAP representative at **(855) WITH-HAP (948-4427)** or visit **hap.org/plans**.

Where can I get help choosing a HAP health plan?

Are you shopping for an individual or family plan for the first time? Or are you a current HAP member? Either way, we have a plan for you.

For help choosing a plan:

- Visit **hap.org/plans**.
- Call one of our knowledgeable, certified HAP representatives at **(855) WITH-HAP (948-4427)**.
- Talk to your agent.

Can I be denied coverage?

The Affordable Care Act was designed to improve access to health care for everyone. Under the ACA, you can't be denied coverage or charged a higher rate because of a pre-existing medical condition.

The ACA requires most Americans to have health insurance. If you don't have coverage through an employer health plan, Medicare or Medicaid, you'll need to get it on your own.

Am I eligible for Medicare or Medicaid?

Medicare

Medicare is the federal health insurance program for people age 65 or older. Medicare also covers those under 65 with certain disabilities or end-stage renal disease. HAP has health plans to help pay for health care costs not covered by Medicare. Visit hap.org/medicare to see Medicare plan options.

If you're currently enrolled in Medicare, you cannot enroll in a qualified health plan through the Health Insurance Marketplace.

Medicaid

Medicaid is a state-administered health insurance program for:

- Low-income families and children
- Pregnant women
- Older people
- People with disabilities

Medicaid coverage may have lower premiums or out-of-pocket costs than ACA plans found on the Health Insurance Marketplace. Those covered by Medicaid aren't eligible to receive subsidies for ACA plans.

If you're not eligible for Medicaid and you live in certain counties, you may qualify for the Healthy Michigan Plan through HAP Midwest. Visit michigan.gov/healthymiplan to check your eligibility.

What do I need to do before I can enroll?

Prepare to enroll by following the steps below. Or call a HAP representative at **(855) WITH-HAP (948-4427)** to walk you through the process.

1. If you currently have health coverage, learn how your plan works and what your costs are to use it (for example, premiums, deductibles, copays, coinsurance, etc.).

2. Visit hap.org/plans to review your health plan options. If you're already a HAP member, see if your current plan still meets your needs. Our website has tools to help you find the right plan for you and your family.

Go to hap.org/plans to:

- Get help choosing a plan
- Estimate plan costs

3. Write down any questions you may have.

4. Gather information about your household:

- Number of family members who need coverage
- Monthly household income
- Personal information on each person to be covered (date of birth, Social Security number, etc.)

5. Set a monthly health care budget so you know how much you can spend on premiums and out-of-pocket costs.

6. List the primary care doctors for all family members who'll be covered. If you're enrolling in an HMO plan, you'll need to choose a primary care physician or one will be assigned for you. To see if your doctor is in the HAP network, visit hap.org and click on *Doctors* at the top of the page.

7. Make a list of all medications you and your family members take. And check if those medications are covered in the health plan's covered drug list, also called a formulary. Visit hap.org/prescriptions for a list of covered drugs.

8. If you're enrolling during a special enrollment period, gather the required proof of the qualifying event.

Let's get you covered!

Now that you've gathered your information and checked out our plans, call one of our experts at **(855) WITH-HAP (948-4427)** to get started.

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

©2018 HAP – a nonprofit company



Once You're a HAP Member



Once You're a HAP Member

Health care should be simple. So we've put together this guide to help you use your HAP plan. This will tell you how to find information, get services and manage your account and payments. If you need more help, look online at **hap.org** or call HAP Customer Service at the number on your ID card.

Getting started

- 1. Make your initial payment.** Call Accounts Receivable at **(888) 735-2542 (TTY: 711)** to make your payment if you didn't make your first premium payment when you enrolled.
- 2. Get your ID card.** Your ID card will be mailed to you after your effective date. You can also download it from your online member account or on your smartphone.
- 3. Check out your HAP online member account.** You can do everything from managing your plan to accessing a doctor online. Have your member ID card ready and go to **hap.org** to register.
- 4. Select a primary care physician.** You can select your PCP online by logging in at **hap.org**. If you need help selecting a PCP, reach out to us by calling:
 - **Your personal service coordinator team.** They're available to help you learn about your HAP plan and get started using it. Call **(866) 766-4712 (TTY: 711)** to be connected to a team member.
 - **Our automated services line.**
 1. Select a PCP from our provider directory.
 2. Write down their PCP ID code
 3. Call the number on your member ID card.
 4. Follow the prompts to update your PCP. You can also search by provider name if you do not have the ID code.
 - **A PCP selection specialist.** Call **(888) 742-2727 (TTY: 711)**.
- 5. Download our free apps.** Manage your health care from your smartphone or tablet.
- 6. Take a health assessment.** We support your health every day with tools like iStrive® for Better Health, our digital wellness manager. Start with your health assessment for a snapshot of your current health and well-being. Then use that information to pick health areas you want to improve.

Quick and easy access

Online account management

Your health plan is right at your fingertips at **hap.org**. Once you register, you'll have 24/7 access to free and secure digital self-service tools to:

- Pay your premium online.
- Talk with a doctor online 24/7 through our new telehealth program.
- Estimate costs for medical services and facilities with our new Health Care Cost Estimator.
- Search our list of doctors, hospitals, urgent care centers or pharmacies.
- View the plan documents that explain your benefits. Find out what's covered and what your out-of-pocket costs are.
- View your claims summary, including your history, and Explanations of Benefits.
- Access pharmacy tools to look up covered drugs.
- Enroll in Pharmacy Advantage home-delivery pharmacy service for specialty drugs and 90-day medication fills.
- Send and receive secure messages with HAP Customer Service.
- Register for HAP member health and wellness events.
- View your health reminders to see when you're due for preventive services.
- Access iStrive® for Better Health, our free digital wellness manager, and take an interactive health assessment.
- Sign up for paperless options.

Online doctor visits 24/7

Getting health care online has never been easier. HAP has partnered with American Well® to bring you telehealth services. Doctors are available 24/7 for live, online visits.

Telehealth can help you with:

- Nonemergency illnesses: Doctors can help with minor issues, such as colds, flu, headache, rashes, sinus infections, pinkeye and other minor conditions.
- Prescriptions: If it's medically necessary, doctors can prescribe some medications through telehealth.
- Secure online visits: Enjoy peace of mind during your online doctor visit. American Well's private, secure site complies with HIPAA, the Health Insurance Portability and Accountability Act.
- Licensed, board-certified doctors: Review doctor profiles and choose the best one for you.
- Access on all devices: You can connect with doctors on your smartphone, tablet and computer. This makes it easy to get care whenever and wherever you may need it.



Mobile apps

Get access to doctors, pharmacies, emergency services and more – right on your phone or tablet. You can get the following three apps in the Apple or Google app stores.

HAP OnTheGo

With our HAP app, you can:

- Find a doctor, urgent care center or hospital. Get directions and contact information. And schedule appointments using the “click to call” feature.
- View member ID cards for anyone on your plan. You can also email or fax them to a doctor’s office, hospital or pharmacy.
- Get health information and interactive tools to help you understand and manage your symptoms and conditions.
- Access HAP contact information. Reach us by phone, mail, email or in person.

Assist America

HAP provides global emergency assistance through Assist America.* You can be worry-free when traveling more than 100 miles away from home or even in another country – for no more than 90 days in a row.

We’ll work with Assist America to help you:

- Find the right hospital.
- Get an emergency medical evaluation.
- Replace prescriptions that have been lost or left behind.
- Get help with luggage and documents and much more.

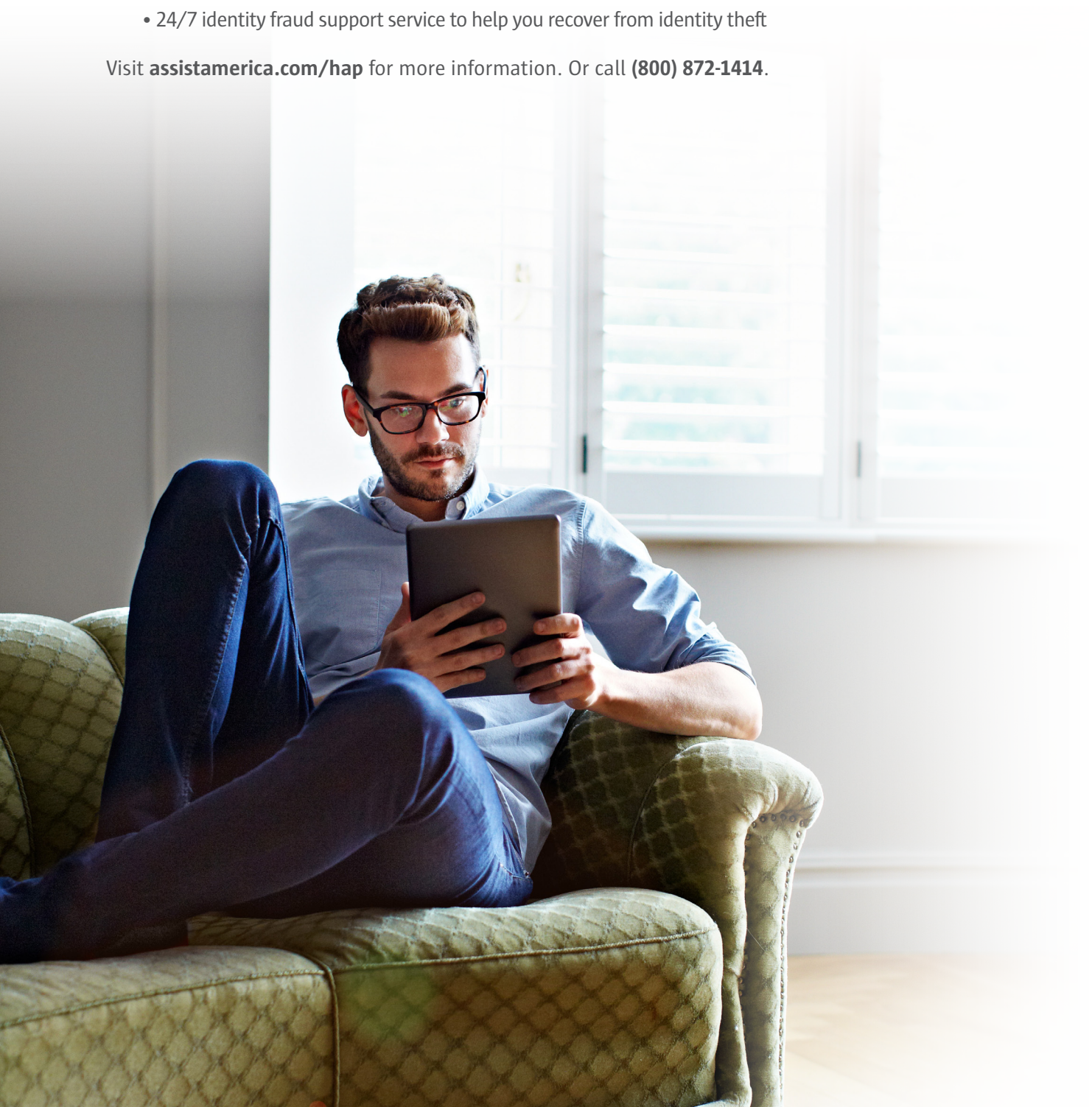
*Medicaid members aren’t eligible for Assist America benefits.

Identity theft protection

Through our partnership with Assist America, eligible HAP members also have access to:

- Credit card and document registration
- Credit and debit card internet surveillance for cards registered online
- Phone assistance for lost and stolen credit cards and documents
- 24/7 identity fraud support service to help you recover from identity theft

Visit assistamerica.com/hap for more information. Or call **(800) 872-1414**.



Managing your HAP plan

HAP makes it easy to purchase and pay for your plan. Whether you want the ease of paying online or through the mail, just let us know.

Pay your bill online

Once you're a member, you can register at **hap.org** using your member ID. Your online member account allows you to pay bills and manage your account 24/7. Click on the *Bill Pay* icon to:

- Add, delete or change your payment method.
- Update your credit card or bank information.
- Make a one-time premium payment by credit card, debit card or bank account.
- Set up automatic monthly payments.
- View your online payment history.
- Request a paper invoice for your files.

You'll be able to see any unpaid invoices as soon as you register for Bill Pay. When you pay online, you'll get an email confirmation once the payment is successfully withdrawn from your account.

Receive paper invoices

The Bill Me option allows you to request a paper bill when you enroll.

If you choose this option, please:

- Allow three to five days for mail delivery and processing. We must receive and process your payment before the bill's due date. This will ensure that you avoid cancellation and continue to have active coverage and access to your benefits.
- Include the payment coupon at the bottom of the invoice with your payment.

Payment and delinquency process

Initial premium payment

The initial premium payment for health plans purchased through HAP must be received and processed prior to the effective date of coverage. The government requires that carriers cancel coverage for members who do not meet this payment requirement.

For quick processing, we recommend calling Accounts Receivable for assistance at **(888) 735-2542 (TTY: 711)** to make your initial or ongoing payment.

Monthly payment processing

When you have selected auto pay for your monthly premiums, payments are processed on or around the 26th of each month. When the payment date falls on a weekend or holiday, payment is withdrawn on the next business day.

Delinquency process for nonpayment of monthly premiums

This process occurs if your account becomes delinquent after you have paid your first month's premium. If payment is not received by the due date, you won't have access to medical or prescription benefits as of the first day of delinquency. The process is as follows:

1. You'll be sent a notification of delinquency.
2. Your coverage will be terminated at the end of the first month of delinquency or nonpayment of the premium.
3. You'll have to pay any medical charges you incur if premiums are not paid in full.

Special enrollment payment

For members who enroll during a special enrollment period, different payment rules apply. The effective date of coverage and the due date of your initial payment may vary. If the effective date of coverage is prior to the date your application was submitted and approved, according to government guidelines, multiple months' premiums may be withdrawn at the same time.

Insufficient funds

If your account doesn't have sufficient funds available to make your payment, contact Accounts Receivable at **(888) 735-2542** to address the situation. HAP isn't responsible for any related charges that you may incur with your financial institution.

Cancellation of coverage

To request cancellation of your entire contract, you must send the request in writing. If a dependent on your contract who is 18 years of age or older is being canceled, the request for cancellation must come from the dependent.

Email your written request and reason for cancellation to **yourhap@hap.org**. Or mail your request to:

HAP
Customer Service Correspondence Department
2850 W. Grand Blvd.
Detroit, MI 48202

Upon canceling, you can verify that your coverage has ended by calling Customer Service at the number on your member ID card. If you cancel, your coverage will not continue past the date through which your coverage is paid.

Precertification

Precertification allows us to make sure that you are getting medically appropriate services. For some services and supplies, you must get precertification from HAP. Emergency or urgent care never require precertification.

When precertification is necessary, you must notify HAP before buying supplies, undergoing a procedure or receiving treatment. If you do not get precertification, coverage will be denied. Precertification may be granted for a single service, purchase or procedure or for a specific period of time. Make sure you know when you need precertification to avoid having coverage denied.

For a complete list of services and supplies that require precertification, call Customer Service at **(800) 944-9399**. See a partial list below.

Precertification (continued)

Inpatient services

All inpatient services require precertification.

The exception is hospital stays for a mother and her newborn. This includes stays up to 48 hours after a vaginal delivery and 96 hours after a cesarean section.

Outpatient services

All outpatient services also require precertification. This includes:

- Durable medical equipment charges over \$1,500, including rentals and repairs
- Prosthetic appliance and orthotic appliance charges over \$1,500
- Oral and maxillofacial services, except emergency services
- High-tech radiology examinations, including, but not limited to:
 - Positron-emission tomography scans
 - MRI
 - CT scans
 - Nuclear cardiology studies
- Selected injectable drugs
- Supplemental feeding administered via tube or IV
- Transplants and evaluations for transplants
- Genetic testing
- Clinical trials for cancer care

Emergency care

You do not need authorization for urgent or emergency care. You are always covered for urgent or emergency care. This includes mental health services. In case of a serious illness or injury, you should go directly to the nearest emergency room or urgent care center or call 911.

If you need extended inpatient care, HAP reserves the right to transfer you to an alternative facility within the HAP service area.

Thanks for choosing HAP

We know there are many aspects to getting health care. We're here to help. If you have any questions, please call the number on your member ID card, and we'll be happy to help with whatever you need.