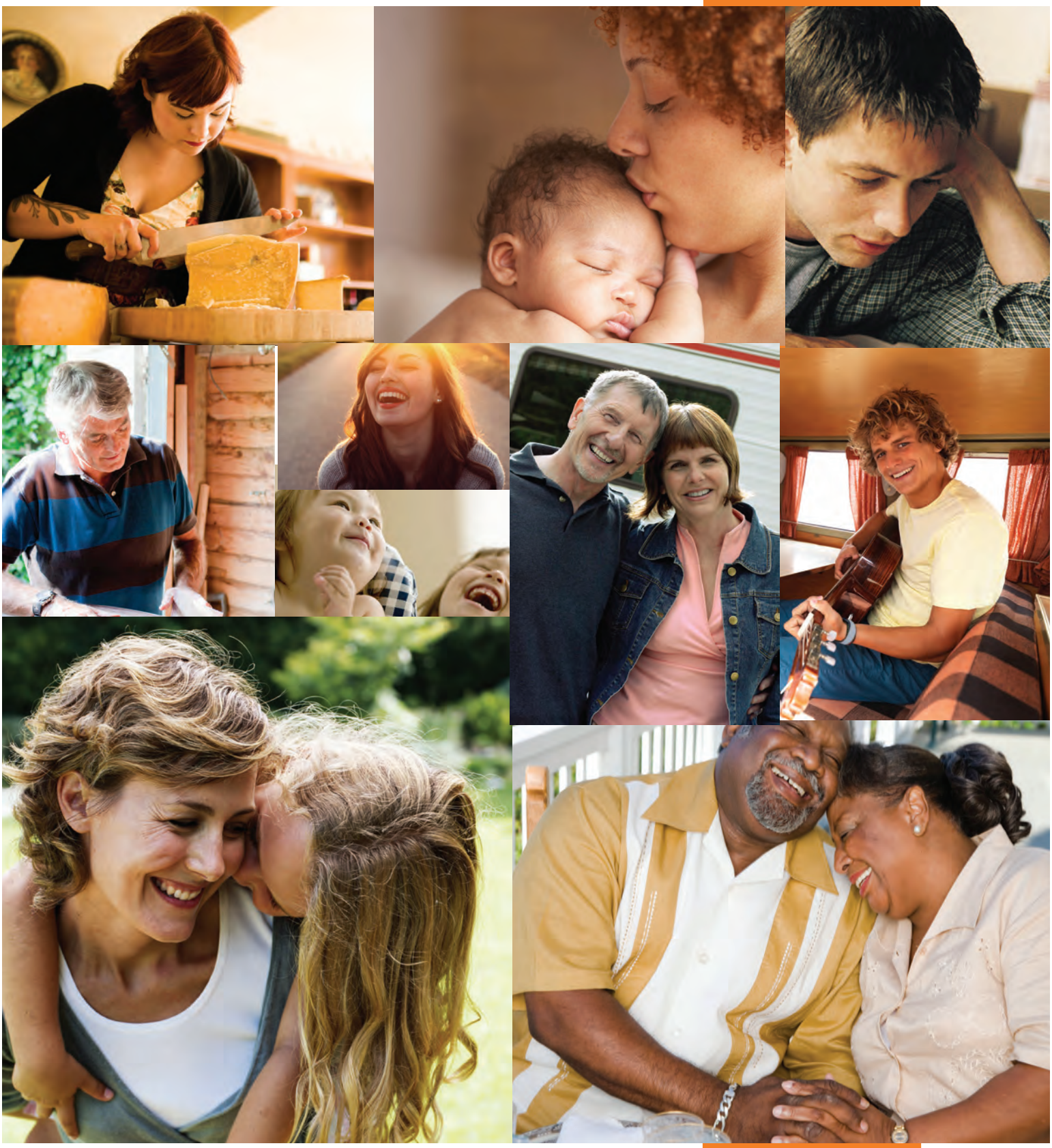

Welcome to the plan where you belong.

Offered by Alliance Health and Life Insurance Company, Inc.

hap | Personal Alliance™

Complete Coverage for Individuals and Families

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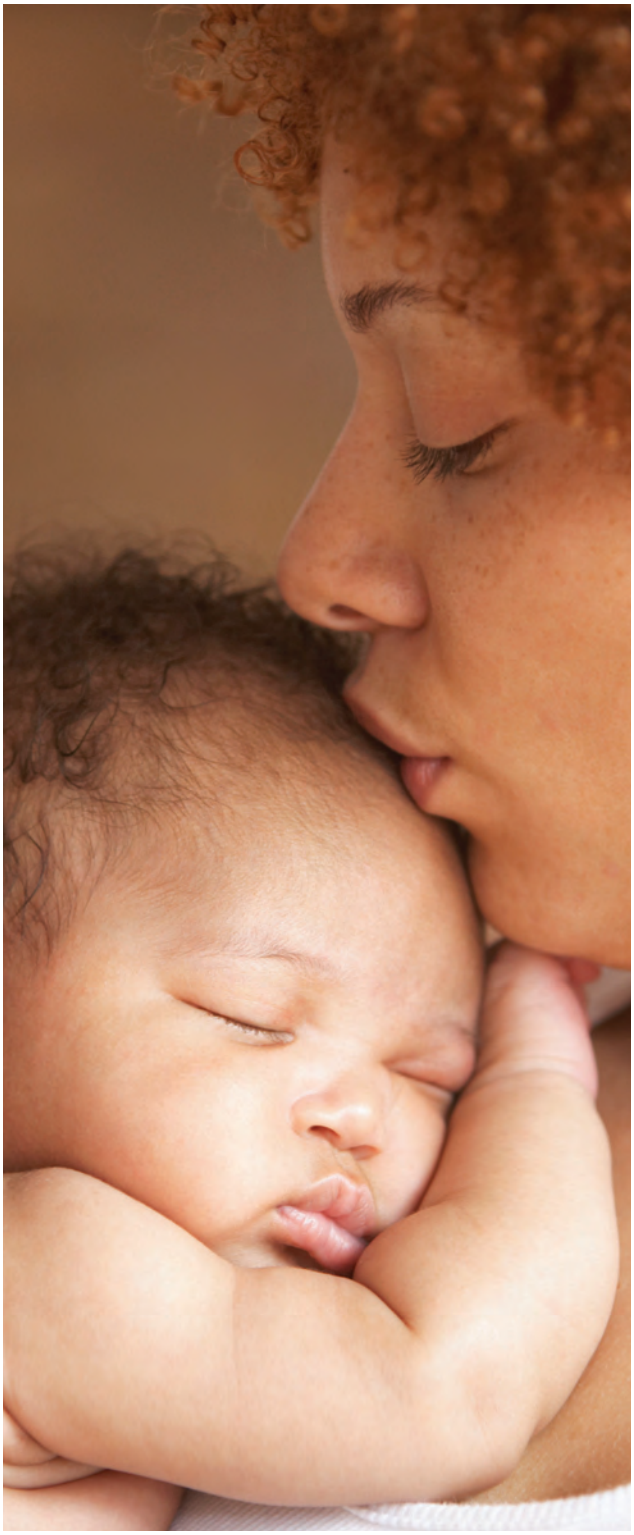

Other health plans make you a member. We make you feel like a member of the family.

You don't fit in a box. You need more than a health plan, you need a place where you belong. You need a team that will back you up. At HAP, we take your health very personally. We believe a health plan should be more than doctors and deductibles. After all, this is your life and future we are talking about. We get it. We understand you want to know you'll be covered, listened to and treated well. With HAP, you'll find exactly that. A home that protects your health and makes you feel welcome at every turn. Personal care. Exceptional customer service. Excellent coverage. The place you belong is inside HAP.

When you choose HAP Personal Alliance, you're choosing more.

We know what you want. Of course you want more options and fewer headaches. But you also want choices that fit your unique situation. Whether you are self-employed, in transition or somewhere in between, you still deserve to get the best. That's what we'll give you. You'll have your choice of affordable plans supported by our team of award-winning customer service representatives. We're constantly making improvements to our plans to enhance your quality of life and your peace of mind.

- **We give you choices** – Choose from 10 of our Preferred Provider Organization (PPO) plans with both in-network and out-of-network benefits. Plan choices include PPO, short-term and health savings account (HSA) options. Select the plan with deductibles, co-insurance and out-of-pocket maximums that are right for you.
- **We give you the leading doctors** – The doctors you want are with us, and now, they're with you. You'll have your choice of the region's best doctors and hospitals in the area.
- **We give you flexibility** – Life changes and so do your needs. When you're in transition, our Short-Term Products are affordable options when you need a little time and temporary coverage.
- **We give you extras** – With HAP Personal Alliance, you'll get special discounts on services such as LASIK and Weight Watchers®.
- **We put the "person" in personal** – As with all HAP plans, as our Personal Alliance member you'll be supported by our award-winning customer service. Yes, real people will be with you every step of the way, answering all your questions and taking care of your needs.
- **We want you to be healthy** – You'll get personalized wellness programs and preventive care to maintain and improve your well-being. (Excludes short-term plans.)
- **We don't want you to wait** – It takes only 30 minutes to apply, and coverage can begin as soon as the first or fifteenth day of the month following acceptance.

HAP partnered with Assist America — your home away from home.

With HAP Personal Alliance, you'll be connected to Assist America, the premier provider of global emergency services. If you ever become ill or injured while traveling, one simple phone call will connect you to Assist America's 24/7, state-of-the-art Operations Center with worldwide response capabilities. Assist America arranges and pays for all of the assistance services they provide without limits on the covered costs – including emergency medical evacuation, compassionate visit, and medical repatriation. Whether you are across the country or across the ocean, we've got you covered*.

*HAP still covers you worldwide for emergency and urgent care. Assist America does not replace your HAP coverage. Remember: If you have a medical emergency and are admitted to a hospital that is not affiliated with HAP, notify HAP within 48 hours using the number on the back of your HAP ID card.

All of our little extras make HAP exceptional.

You can tell how much your friends truly care by the little things they do for you. Same with a health care provider. We believe you deserve every advantage possible to keep you in the best health possible. Thanks to the HAP Advantage* program, you'll receive more money-saving discounts and have access to a variety of health and wellness-related activities, entertainment and Web sites, many which are local to southeast Michigan:

- **FitZone for Women** — Save 60% off registration and $5 off monthly dues at the Livonia, Grand Blanc and Waterford locations.
- **Chiropractors** — Save 15% on non-covered chiropractic services from participating chiropractors.
- **YMCAs of Metro Detroit** — No sign-up fee at the 11 Metro Detroit YMCAs — a savings of up to $250 for HAP members.
- **Henry Ford LASIK** — Save $562 on LASIK services (both eyes).

All this, on top of the additional extras you receive just for being a HAP Personal Alliance member:

- **Weight Watchers®** — As part of HAP's commitment to healthy living and preventive care, qualified members can join Weight Watchers® for just $25 and HAP will pay the rest of the enrollment fee. That's a great savings passed on to you!
- **Pharmacy Advantage Home Delivery** — In addition to filling your prescriptions at a retail pharmacy, we offer mail order prescription service through Pharmacy Advantage Home Delivery. You'll get a 90-day supply of your medication, saving you time and money by eliminating monthly trips to the pharmacy. To learn more, visit **www.hap.org/formulary/mo_prescriptions.php**.
- **iStrive℠ for better health** — HAP has partnered with HealthMedia® to offer this revolutionary digital health coaching program, exclusively for members. iStrive℠ programs offer a free, confidential health risk assessment and a suite of additional tools to help you learn how to live a healthier life. Log on at hap.org and go to iStrive℠ for more information.

Award-winning customer service starts with better listening.

Actions speak louder than words. And at HAP, you will see our customer service team in action because of how we truly listen. HAP's Client Service Specialists provide fast, accurate and personal service to members. And just to make sure our relationship gets off to a healthy start, we provide you with an assigned personal service coordinator for the first two years of your membership. Imagine a real human being available just for you to answer all of your questions, find you solutions and guide you along the way.

*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 policy, Riders or Member Handbook or otherwise payable by Alliance. 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.

Our online tool suite makes the world of health care easy to navigate.

You've got everything you need for good health at your fingertips. We want to empower you to make better choices and changes that lead to better health. You've got enough complications in life to deal with. That's why managing your health care needs to be easy. Simply register at hap.org for access to convenient, personalized and secure online tools:

- Benefits and coverage information
- Find a doctor
- Claims
- Pharmacy claims
- Co-pays — information on emergency, urgent care, physicians office or pharmacy co-pays
- Request a new ID card
- Prescription search
- Health reminders
- iStrive℠

We've got everything you need right here, under one roof. Here's our list of HAP Personal Alliance plan options.

HAP Personal Alliance™ Preferred Provider Organization (PPO) Plans

Every person is unique. Finding the right plan that fits your unique needs makes all the difference. And it makes choosing among the plans easier. We want to empower you with the ability to make the best choices for your life. Having five different PPO plans means you can personally select a plan to fit your lifestyle and budget.

	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	OPTIONAL BENEFITS
	In-Network		You may purchase the following to add to your plan: • Prescription (3 coverage options) • Vision Hardware • Delta Dental® plans (3 coverage options)
PPO 500	$500 Individual $1,000 Family	$1,500 Individual $3,000 Family	
PPO 1000	$1,000 Individual $2,000 Family	$3,500 Individual $7,000 Family	
PPO 2000	$2,000 Individual $4,000 Family	$4,500 Individual $9,000 Family	
PPO 3000	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family	
PPO 5000	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	

HAP Personal Alliance™ Health Savings Account (HSA) Plans

Life is unpredictable. In today's ever-changing world, everyone needs to find ways to anticipate what will come and ways to save money. It's the smart thing to do. Investing in an HSA is smart too. And with Alliance having two options, it's smarter still.

	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	OPTIONAL BENEFITS
	In-Network		You may purchase the following to add to your plan: • Vision Hardware • Delta Dental® plans (3 coverage options)
HSA 2500	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	
HSA 5000	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	
Prescription	Covered; subject to deductible		

HSA Defined

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

To be eligible to set up an HSA and make annual contributions, you must be covered by a qualified High-Deductible Health Plan (HDHP) like HAP's Personal Alliance HSA 2500 or 5000 plans.

A HDHP is a health insurance plan with minimum annual deductions, out-of-pocket maximums and contribution levels set by the IRS and adjusted annually for inflation.

How an HSA Works

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

HSA Benefits

Tax-advantaged

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

Flexible

- The money grows and remains with you, even when you change health plans or retire — and even if you're no longer eligible to make contributions. After age 65, or in cases of disability, the funds in the account can be used for non-qualified expenses.
- As long as you're covered by a qualified HDHP, you, your family members or anyone else may contribute to your HSA up to the maximum annual contribution limit.
- HAP's preferred HSA partner is the ACS/BNY Mellon HSA Solution®.
  To learn more, check out the ACS/BNY Mellon Web site at **www.hsamember.com**.

HAP Personal Alliance™ Short-Term Plans

Sometimes you find yourself needing a short-term health plan solution, whether you are between jobs or just in transition. But just because it's a temporary fix, that doesn't mean it can't deliver quality care and coverage. Our three short-term solutions are long-term minded when it comes to the quality of care that will help you live better tomorrow. Each plan is available for six months or less (up to 185 days).

	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	OPTIONAL BENEFITS
In-Network			**Optional benefits unavailable for Short-Term plans.**
Short-Term 500	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	
Short-Term 1000	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	
Short-Term 2000	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	
Prescription	Covered; subject to deductible and coinsurance		

Selecting the right health plan has never been easier.

You Visit the Doctor but Want to Keep Out-of-Pocket Costs Low:
PPO 500 $$$

You'd Like to Keep a Balance Between Coverage and Cost:
PPO 1000 $$
PPO 2000 $$

You're Looking for Low Monthly Premiums:
PPO 3000 $
PPO 5000 $

You Want a Plan That Works With an HSA:
HSA 2500 $$
HSA 5000 $$

You Need a Short-Term Plan for 6 Months or Less:
Short-Term 500 $
Short-Term 1000 $
Short-Term 2000 $

Need more help choosing? Check out the details of each plan on pages 9–18. You also have the option to add prescription, vision and dental benefits to any long-term PPO or HSA plans (not available with short-term plans).

Come on in and make yourself at home.

Now that you've seen what HAP has to offer, we hope you step inside. Our representatives are ready to help you personalize options and choose benefits that best fit your lifestyle and your budget. Your health and your family are your top priorities, so why shouldn't they be ours? Whichever plan you go with, you can take comfort in knowing that HAP is right where you belong. We're looking forward to making you feel like a member of our family.

Still have questions? Contact us anytime at (855) WITH HAP or (855) 948-4427 or e-mail us at **personalalliance@hap.org**.

What's covered in your HAP Personal Alliance health plan?

No matter what you need, we've got an option that will work for you. Check out the details of each plan on pages 9–18.

Schedule of Benefits

HAP PERSONAL ALLIANCE PPO 500						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$500/$1,000	$1,000/$2,000	20%	50%	$1,500/$3,000	$3,000/$6,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Copay will not be applied to deductible or out-of-pocket maximum. One copay is applied to an office visit that includes injections, lab tests, and/or x-rays performed on the same day.
Allergy Testing and Injections	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Prescription Drugs (Generic/Preferred/Non-preferred)	$15/$30/$50 -or- $15/$30/$50 (after $500 deductible per person for all tiers) -or- $10/$60/$60 -or- No Rx		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance PPO 500** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE PPO 1000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$1,000/$2,000	$2,000/$4,000	20%	50%	$3,500/$7,000	$7,000/$14,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Copay will not be applied to deductible or out-of-pocket maximum. One copay is applied to an office visit that includes injections, lab tests, and/or x-rays performed on the same day.
Allergy Testing and Injections	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Prescription Drugs (Generic/Preferred/Non-preferred)	$15/$30/$50 -or- $15/$30/$50 (after $500 deductible per person for all tiers) -or- $10/$60/$60 -or- No Rx		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance PPO 1000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE PPO 2000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$2,000/$4,000	$4,000/$8,000	20%	50%	$4,500/$9,000	$9,000/$18,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Copay will not be applied to deductible or out-of-pocket maximum. One copay is applied to an office visit that includes injections, lab tests, and/or x-rays performed on the same day.
Allergy Testing and Injections	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444.5755
Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Prescription Drugs (Generic/Preferred/Non-preferred)	$15/$30/$50 -or- $15/$30/$50 (after $500 deductible per person for all tiers) -or- $10/$60/$60 -or- No Rx		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance PPO 2000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE PPO 3000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$3,000/$6,000	$6,000/$12,000	0%	50%	$3,000/$6,000	$10,000/$20,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Outpatient office visits limited to 4 per person per benefit period. Copay will not be applied to deductible or out-of-pocket maximum. One copay is applied to an office visit that includes injections, lab tests, and/or x-rays performed on the same day.
Allergy Testing and Injections	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Prescription Drugs (Generic/Preferred/Non-preferred)	$15/$30/$50 -or- $15/$30/$50 (after $500 deductible per person for all tiers) -or- $10/$60/$60 -or- No Rx		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance PPO 3000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE PPO 5000

DEDUCTIBLE		COINSURANCE (Member)		OUT-OF-POCKET MAXIMUM Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		LIFETIME MAXIMUM BENEFIT
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$5,000/$10,000	$10,000/$20,000	20%	50%	$10,000/$20,000	$20,000/$40,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Outpatient office visits limited to 4 per person per benefit period. Copay will not be applied to deductible or out-of-pocket maximum. One copay is applied to an office visit that includes injections, lab tests, and/or x-rays performed on the same day.
Allergy Testing and Injections	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	$25 copay. Not subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Prescription Drugs (Generic/Preferred/Non-preferred)	$15/$30/$50 -or- $15/$30/$50 (after $500 deductible per person for all tiers) -or- $10/$60/$60 -or- No Rx		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance PPO 5000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE HSA 2500						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$2,500/$5,000	$5,000/$10,000	0%	50%	$2,500/$5,000	$10,000/$20,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	Subject to deductible	Subject to deductible and coinsurance	
Allergy Testing and Injections	Subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	Subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	Subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	Subject to deductible		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	Subject to deductible		
Emergency Ambulance Services	Subject to deductible		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of in- and out-of-network services
Home Health Care	Subject to deductible	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible	Subject to deductible and coinsurance	60 visits combined per benefit
Durable Medical Equipment (DME)	Subject to deductible	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Prescription Drugs (Generic/Preferred/Non-preferred)	Subject to deductible		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance HSA 2500** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE HSA 5000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$5,000/$10,000	$10,000/$20,000	0%	50%	$5,000/$10,000	$20,000/$40,000	No Lifetime Maximum Benefit

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Calendar Year**		
Preventive Care			
Preventive Office Visits	Covered	Not Covered	
Periodic Physical Exams	Covered	Not Covered	
Well Baby / Child Exams	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exams	Covered	Not Covered	Routine Eye Exam limited to one per year
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	Screening and diagnostic
Outpatient and Physician Services			
Office Visits	Subject to deductible	Subject to deductible and coinsurance	
Allergy Testing and Injections	Subject to deductible	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	Subject to deductible	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	Subject to deductible	Subject to deductible and coinsurance	Manipulation of the spine for subluxation; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	Subject to deductible		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	Subject to deductible		
Emergency Ambulance Services	Subject to deductible		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible	Subject to deductible and coinsurance	60 visits combined per benefit
Durable Medical Equipment (DME)	Subject to deductible	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at (800) 444-5755
Inpatient Services	Subject to deductible	Subject to deductible and coinsurance	Limited to 15 days per person per benefit period
Mental Health Services (Outpatient Services)	Subject to deductible	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Chemical Dependency Services (Outpatient Services)	Subject to deductible	Subject to deductible and coinsurance	Limited to 5 outpatient visits per person per benefit period
Other Benefits			
Prescription Drugs (Generic/Preferred/Non-preferred)	Subject to deductible		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Maternity Services	Not Covered	Not Covered	Services covered as required under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
Optional Benefits (Riders available)			
Vision Hardware	Covered -or- Not Covered		Must meet Alliance guidelines. One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered, with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.
Dental	Delta Dental Low -or- Delta Dental Medium -or- Delta Dental High -or- No Dental		

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance HSA 5000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE SHORT-TERM 500						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$500/$1,000	$1,000/$2,000	20%	50%	$1,000/$2,000	$2,000/$4,000	$2 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Fiscal Benefit Period**		
Preventive Care			
Preventive Office Visits	Not Covered	Not Covered	
Periodic Physical Exams	Not Covered	Not Covered	
Well Baby / Child Exams	Not Covered	Not Covered	
Immunizations	Not Covered	Not Covered	
Routine Eye and Hearing Exams	Not Covered	Not Covered	
Related Lab Tests and X-Rays	Not Covered	Not Covered	
Pap Smears	Not Covered	Not Covered	
Outpatient and Physician Services			
Mammograms	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Screening and diagnostic
Office Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Allergy Testing and Injections	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Manipulation of the spine for subluxation only; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			
Inpatient Services	Not Covered	Not Covered	
Mental Health Services (Outpatient Services)	Not Covered	Not Covered	
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Not Covered	Up to 40 visits per benefit period or state-mandated annual aggregate dollar amount, whichever is greater
Other Benefits			
Prescription Drugs (Including Birth Control Drugs and Devices)	Subject to deductible and coinsurance		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Not Covered	Not Covered	
Dental	Not Covered	Not Covered	
Maternity Services	Not Covered	Not Covered	

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance Short-Term 500** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE SHORT-TERM 1000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$1,000/$2,000	$2,000/$4,000	20%	50%	$2,000/$4,000	$4,000/$8,000	$2 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Fiscal Benefit Period**		
Preventive Care			
Preventive Office Visits	Not Covered	Not Covered	
Periodic Physical Exams	Not Covered	Not Covered	
Well Baby / Child Exams	Not Covered	Not Covered	
Immunizations	Not Covered	Not Covered	
Routine Eye and Hearing Exams	Not Covered	Not Covered	
Related Lab Tests and X-Rays	Not Covered	Not Covered	
Pap Smears	Not Covered	Not Covered	
Outpatient and Physician Services			
Mammograms	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Screening and diagnostic
Office Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Allergy Testing and Injections	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Manipulation of the spine for subluxation only; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			
Inpatient Services	Not Covered	Not Covered	
Mental Health Services (Outpatient Services)	Not Covered	Not Covered	
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Not Covered	Up to 40 visits per benefit period or state-mandated annual aggregate dollar amount, whichever is greater
Other Benefits			
Prescription Drugs (Including Birth Control Drugs and Devices)	Subject to deductible and coinsurance		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Not Covered	Not Covered	
Dental	Not Covered	Not Covered	
Maternity Services	Not Covered	Not Covered	

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance Short-Term 1000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Schedule of Benefits

HAP PERSONAL ALLIANCE SHORT-TERM 2000						
DEDUCTIBLE		**COINSURANCE** (Member)		**OUT-OF-POCKET MAXIMUM** Deductibles, Coinsurance and Copays (if any) accumulate toward the Out-of-Pocket Maximum unless stated otherwise.		**LIFETIME MAXIMUM BENEFIT**
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Individual/Family	Individual/Family			Individual/Family	Individual/Family	
$2,000/$4,000	$4,000/$8,000	20%	50%	$4,000/$8,000	$8,000/$16,000	$2 Million

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	**Fiscal Benefit Period**		
Preventive Care			
Preventive Office Visits	Not Covered	Not Covered	
Periodic Physical Exams	Not Covered	Not Covered	
Well Baby / Child Exams	Not Covered	Not Covered	
Immunizations	Not Covered	Not Covered	
Routine Eye and Hearing Exams	Not Covered	Not Covered	
Related Lab Tests and X-Rays	Not Covered	Not Covered	
Pap Smears	Not Covered	Not Covered	
Outpatient and Physician Services			
Mammograms	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Screening and diagnostic
Office Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Allergy Testing and Injections	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Other Injections / Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Back Care/Chiropractic Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Manipulation of the spine for subluxation only; 20 visits per person per benefit period (combined In- and Out-of-Network)
Outpatient Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Radiation / Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Eye Examinations (for medical reasons)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include lenses/frames/contacts
Audiology Examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Does not include hearing aids
Emergency Services			
Emergency Room Services	$250 copay		Must meet Alliance emergency guidelines ER copay waived if admitted
Urgent Care Facility Services	$50 copay		
Emergency Ambulance Services	$100 copay		Emergency transport only

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Inpatient Hospital Services			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 coinsurance limit. This penalty is imposed for each incident of noncompliance.
Semi-Private Room	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Therapy Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Surgery and Related Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Related Lab Tests and X-Rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Physician / Professional Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Ancillary Services			Limitations are a combination of In- and Out-of-Network services
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 visits per benefit period
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	210 days lifetime
Physical Therapy, Speech Therapy, Occupational Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	60 visits combined per benefit period
Durable Medical Equipment (DME)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	100 days per benefit period
Mental Health Services / Chemical Dependency Services			
Inpatient Services	Not Covered	Not Covered	
Mental Health Services (Outpatient Services)	Not Covered	Not Covered	
Chemical Dependency Services (Outpatient Services)	Subject to deductible and coinsurance	Not Covered	Up to 40 visits per benefit period or state-mandated annual aggregate dollar amount, whichever is greater
Other Benefits			
Prescription Drugs (Including Birth Control Drugs and Devices)	Subject to deductible and coinsurance		Does not include coverage of drugs for Infertility, Obesity or Smoking Cessation. Contraceptives are included. All prescriptions must meet Alliance guidelines.
Vision Hardware	Not Covered	Not Covered	
Dental	Not Covered	Not Covered	
Maternity Services	Not Covered	Not Covered	

This Schedule of Benefits is designed to provide an overview of the **HAP Personal Alliance Short-Term 2000** Plan and is subject to the terms and conditions of the actual policy. In case of conflict between this schedule and the policy, the terms and conditions of the policy govern. Alliance PPO Subscribers and Dependents who do not seek services from a network provider will receive services at the **Out-of-Network benefit level**.

Additional Benefit Options

Prescription Drug Plan Options

Three Prescription Drug plan options are offered with HAP Personal Alliance PPO plans:

- $15 Generic/$30 Preferred/$50 Non-Preferred
- $15 Generic/$30 Preferred/$50 Non-Preferred (after $500 deductible per person for all tiers)*
- $10 Generic/$60 Preferred/$60 Non-Preferred

* The $500 prescription deductible is in addition to the medical deductible selected and applies to each member on the contract.

Vision Plan Options

A Vision rider is offered with any of our HAP Personal Alliance PPO or HSA plans. Riders are not available with HAP Personal Alliance Short-Term plans.

Vision Hardware option:

- $80 limit

One pair every 24 months, or 12 months with prescription change. The coverage is limited to STANDARD (basic) lenses and the amount is limited to $40 for frames. Contact lenses in place of eyeglasses are covered with a limitation of $80. Contact lens fitting is not covered. Enrollee responsible for the difference in cost between STANDARD frame cost and the frame selected.

Dental Plan Options

Three PPO dental plan options from Delta Dental are offered with HAP Personal Alliance PPO or HSA plans:

- High
- Medium
- Low

DELTA DENTAL®

HAP Personal Alliance 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]

1, 2 Oral Health in America: A Report of the Surgeon General, 2000.

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]

Great Coverage

You can choose from three plans that cover a wide range of services you may need — from routine services like oral exams, cleanings and X-rays to more complex (and expensive) services like bridges, crowns and dentures. The chart below highlights the three Delta Dental plan options as well as where to find detailed information on each plan, including frequently asked questions.

HIGH PLAN	MEDIUM PLAN	LOW PLAN
Benefit Feature Sheet – Page 21	Benefit Feature Sheet – Page 22	Benefit Feature Sheet – Page 23
Delta Dental PPO (Point-of-Service) FAQ – Page 24	Delta Dental PPO (Point-of-Service) FAQ – Page 24	Delta Dental PPO (Standard) FAQ – Page 25

Call Delta Dental Toll-free for More Information

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

Oral Health and Wellness Information

Watch oral health videos on Delta Dental of Michigan's YouTube channel at **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**.

3 Statistics: Delta Dental Plans Association, September 2009.

Benefit Features for Optional Dental Benefits — High Plan

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

Delta Dental 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 toll-free at (800) 971-4108.

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

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

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

Benefit Features for Optional Dental Benefits — Medium Plan

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

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

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

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

Benefit Features for Optional Dental Benefits — Low Plan

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

Delta Dental 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 toll-free at (800) 971-4108.

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

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

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

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

What Is Delta Dental PPO (Point-of-Service)?

Delta Dental PPO (Point-of-Service) is Delta Dental Plan of Michigan, Inc.'s national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists: our Delta Dental PPO network and our Delta Dental Premier® network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks. Nationwide, more than 72,000 dentists participate in the Delta Dental PPO network, and more than 132,000 dentists participate in the Delta Dental Premier® network.

What Are the Advantages of Choosing a Delta Dental PPO Dentist?

You will receive the highest level of coverage for some services when you go to a Delta Dental PPO participating dentist. In addition, Delta Dental pays PPO dentists directly for covered services based on submitted fees or the amount listed in the local Delta Dental PPO fee schedule, whichever is less. If the Delta Dental PPO fee schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your co-payments 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 co-payments and deductible, if any, when you go to a Delta Dental Premier® dentist for covered services. And, like Delta Dental PPO dentists, Delta Dental Premier® dentists will fill out and file your claim forms for you.

What If I Go to a Non-participating Dentist?

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

Do I Need an ID Card to Receive Care?

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

What If I Have Other Questions?

Please call Delta Dental's Customer Service department toll-free at (800) 971-4108. Delta Dental's DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims and eligibility information, Delta Dental's mailing address and the names of participating dentists near you. In addition, Customer Service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. EST. If you have Internet access, you also can use Delta Dental's Web-based Consumer Toolkit (www.deltadentalmi.com) to access your own benefit, claims and eligibility information 24/7. You can use this Toolkit to search dentist directories, print ID cards and claim forms, sign up for paperless delivery of your Explanation of Benefit (EOB) statements and read oral health tips.

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

What Is Delta Dental PPO (Standard)?

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

What Are the Advantages of Utilizing a Delta Dental PPO Dentist?

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

How Can I Find a Delta Dental PPO Dentist?

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

What If I Go to a Dentist Who Does Not Participate in Delta Dental PPO?

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

Do I Need to Tell My Dentist My Coverage Has Changed?

Yes, it would be helpful if you told your dentist that you have Delta Dental PPO coverage through Delta Dental of Michigan.

Do I Need an ID Card to Receive Care?

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

What If I Have Other Questions?

Please call Delta Dental's Customer Service department toll-free at (800) 971-4108. Delta Dental's DASI system is available 24/7 and can answer many of your questions. DASI can provide you with benefit, claims and eligibility information, Delta Dental's mailing address and the names of Delta Dental PPO dentists near you. In addition, Customer Service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. EST. If you have Internet access, you can also use Delta Dental's Web-based Consumer Toolkit (www.deltadentalmi.com) to access your own benefit, claims and eligibility information 24/7. You can also use this Toolkit to search dentist directories, print ID cards and claim forms, sign up for electronic delivery of your Explanation of Benefit (EOB) statements and read oral health tips.

Things to Know

Medical Underwriting Requirements

Alliance Health and Life Insurance Company (Alliance) individually underwrites each application based on your health history and current health status. Alliance uses your health and medical information to determine the outcome of your application for health coverage, a waiting period for any applicable pre-existing conditions and the premium charged for your coverage under the policy. In some instances, a follow-up medical questionnaire and/or telephone call and/or e-mail may be required to verify information. Medical records may be requested and independent information gathered from other insurance industry entities. Michigan law prohibits genetic testing before issuing, renewing or continuing a policy or certificate in this state. The law also prohibits disclosure of genetic testing as to whether it has been conducted or the results of testing or information.

Duplicate Coverage

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

Pre-existing Conditions

A pre-existing condition is excluded for 12 months unless the applicant provides a HIPAA certificate of credible coverage. The certificate of creditable coverage serves to reduce or eliminate the 12-month exclusion for pre-existing conditions.

The HAP Personal Alliance short-term products have a five-year pre-existing look-back period. This means that a member who has a medical condition for which a prudent person would have sought medical treatment at any time five years or less before enrolling under this policy will not have coverage for that condition. Creditable coverage does not apply to short-term products.

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
- Other reasons permissible by law

Limitations and 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 your Alliance 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.
2. Non-emergent services provided in an emergency setting.
3. Reproductive Care and Family Planning Services — elated to diagnosis, counseling and treatment of infertility, voluntary sterilization such as vasectomy or tubal ligation, voluntary termination of pregnancy, biologicals, contraceptive implant systems and devices.
4. Sex-change procedures.
5. Cosmetic services.
6. Weight-loss programs and services.
7. Experimental and investigational services.
8. Foot care.
9. Mental health and chemical dependency — in excess of the maximum benefit, custodial care, marriage counseling, phone consultations, etc.
10. Nursing services — private duty nursing services, residential and basic nursing services provided in a long-term care facility.
11 Oral, maxillofacial and dentistry services.
12. Dietary drugs, food and food supplements.
13. Therapy and rehabilitation services — beyond the authorized visit limit as approved by Alliance, genetic testing, premarital exams, classes, or marriage counseling, etc.
14. 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.
15. 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.
16. Services required by a third party.
17. 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.
18. Services for any injury, illness or condition that results from or to which a contributing cause was your commission of or attempt to commit a crime, or engagement in illegal occupations.

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

Glossary

Co-insurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to deductible. The deductible may not apply to all services.

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

In-Network (Network)
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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

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

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

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

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

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

Personal Alliance™

hap.org/personal

HAP Personal Alliance is offered by Alliance Health and Life Insurance Company, Inc., a wholly owned subsidiary of Health Alliance Plan.

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