Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-888-999-4347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$500** family in-network: doesn't apply to office visits, ambulance services, preventive, urgent, or emergency care. **$500** person / **$1,000** family out-of-network	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Coinsurance Out-of-Pocket Limit: **In-Network: $750** person; **$1,500** family - Does not include deductible **Out-of-Network: $1,500** person; **$3,000** family - Does not include deductible Out-of-Pocket Maximum: **In-Network: $3,000** person / **$6,000** family **Out-of-Network: $6,000** person / **$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.hap.org or call 1-888-999-4347** for a list of **preferred providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Questions: Call 1-888-999-4347 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-999-4347 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	40% coinsurance after deductible	----------None----------
	Specialist visit	$20 copay per visit	40% coinsurance after deductible	----------None----------
	Other practitioner office visit	$20 PCP Other Practitioner copay per visit/ $20 Specialist Other Practitioner copay per visit	40% coinsurance after deductible	Chiropractic manipulation of the spine for subluxation only - 20 visits per benefit period Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Services require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hap.org.	Generic Drugs	Not Covered	Not Covered	
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Some services require prior authorization.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	----------None----------

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	$30 copay per visit	$30 copay per visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	NOTE: Admissions require Alliance be notified within 48 hours of admission. Failure to notify Alliance within 48 hours could result in a denial of charges.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	40% coinsurance after deductible	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	$20 copay per visit	40% coinsurance after deductible	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	$20 copay per visit	40% coinsurance after deductible	No Charge for Prenatal visits. Prenatal care not covered out of network.
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	**Some services require prior authorization.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Up to100 visits per Benefit Period (In-Network and Out-of-Network)
	Rehabilitation services	$20 copay per visit	40% coinsurance after deductible	Up to 60 combined visits per benefit period- May be rendered at home (In-Network and Out-of-Network)
	Habilitation services	$20 copay per visit	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Up to 100 days per benefit period (In-Network and Out-of-Network)
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Coverage provided for approved equipment based on Alliance guidelines.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Up to 210 days per lifetime (In-Network and Out-of-Network)
If your child needs dental or eye care	Eye exam	$20 copay per visit	40% coinsurance after deductible	Preventive exam not covered out-of-network
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care (Only if meets plan guidelines)
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Non-Emergency Care When Traveling Outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-999-4347. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-888-999-4347 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-888-999-4347. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next page.——————————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,090**
- **Patient pays $1,450**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Co-pays	$20
Co-insurance	$1,010
Limits or exclusions	$170
Total	**$1,450**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $1,790**
- **Patient pays $3,610**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$200
Co-insurance	$230
Limits or exclusions	$2,930
Total	**$3,610**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.