

Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: Individual+Family | **Plan Type:** HVP


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 1-800-422-4641.

| Important Questions | Answers | Why this Matters: |
|--|--|---|
| What is the overall deductible? | \$125 person / \$250 family: doesn't apply to preventive care, office visits, urgent care, emergency care, private duty nursing, DME/P&O, laboratory, pathology, allergy treatment/injections, and pharmacy. | 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. \$2,000 person / \$4,000 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 . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. See www.hap.org or call 1-800-422-4641 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? | Yes. | Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org . |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

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- **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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 copay per visit | Not Covered | -----None----- |
| | Specialist visit | \$20 copay per visit | Not Covered | -----None----- |
| | Other practitioner office visit | \$20 PCP Other Practitioner copay per visit/ \$20 Specialist Other Practitioner copay per visit | Not Covered | Chiropractic manipulation of the spine for subluxation only - 24 visits per benefit year 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) | No Charge after deductible | Not Covered | Laboratory and Pathology do not apply to the deductible. Some services require prior authorization. |
| | Imaging (CT/PET scans, MRIs) | No Charge after deductible | Not Covered | Services require prior authorization. |

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| 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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hap.org . | Generic Drugs | \$10 copay/prescription (retail) | Not Covered | Applies to all categories below. Retail: 30 day supply for non-maintenance drugs at 1 copay; 90 day supply for eligible maintenance drugs at 2 copays; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copays |
| | Preferred brand drugs | \$30 copay/prescription (retail) | Not Covered | |
| | Non-preferred brand drugs | \$60 copay/prescription (retail) | Not Covered | |
| | Specialty drugs | \$60 copay/prescription (retail) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge after deductible | Not Covered | Some services require prior authorization. |
| | Physician/surgeon fees | No Charge after deductible | Not Covered | -----None----- |
| If you need immediate medical attention | Emergency room services | \$200 copay per visit | \$200 copay per visit | Copay will be waived if admitted |
| | Emergency medical transportation | No Charge after deductible | No Charge after deductible | Emergency Transport Only |
| | Urgent care | \$20 copay per visit | \$20 copay per visit | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge after deductible | Not Covered | Some services require prior authorization. |
| | Physician/surgeon fee | No Charge after deductible | Not Covered | -----None----- |

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|---|--|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$20 copay per visit | Not Covered | Some services require prior authorization. Services can be accessed by calling 1-800-444-5755 |
| | Mental/Behavioral health inpatient services | No Charge after deductible | Not Covered | Services require prior authorization. Services can be accessed by calling 1-800-444-5755 |
| | Substance use disorder outpatient services | \$20 copay per visit | Not Covered | Some services require prior authorization. Services can be accessed by calling 1-800-444-5755 |
| | Substance use disorder inpatient services | No Charge after deductible | Not Covered | 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 | Not Covered | No Charge for Prenatal care |
| | Delivery and all inpatient services | No Charge after deductible | Not Covered | Some services require prior authorization. |

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| 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 copay per visit | Not Covered | Up to 60 visits per benefit period |
| | Rehabilitation services | No Charge | Not Covered | Up to 100 combined visits per benefit period - May be rendered at home |
| | Habilitation services | No Charge | 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 | No charge after deductible | Not Covered | Covered for up to 120 days per confinement |
| | Durable medical equipment | Covered | Not Covered | Covered for approved equipment based on HAP's guidelines. Wigs also covered. See plan documents for specific limitations |
| | Hospice service | No Charge after deductible | Not Covered | Up to 210 days per lifetime |
| If your child needs dental or eye care | Eye exam | \$20 copay per visit | Not Covered | No Charge for preventive eye exam |
| | Glasses | Not Covered | Not Covered | -----None----- |
| | Dental check up | Not Covered | Not Covered | -----None----- |

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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
- Long-Term Care
- Routine Foot Care (Only when meets Plan guidelines)
- Cosmetic Surgery
- Non-Emergency Care When Traveling Outside the U.S.
- Vision Hardware (Unless additional rider purchased)
- Dental Care (Adult)

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.)

- Bariatric Surgery
- Infertility Treatment (Only when meets Plan guidelines)
- Routine Eye Care (Adult)
- Chiropractic Care
- Private-Duty Nursing
- Weight Loss Programs
- Hearing Aids

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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 1-800-422-4641. 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 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. 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/ofir>, e-mail ofir-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.-----

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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 \$7,240
- Patient pays \$300

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 | \$130 |
| Co-pays | \$20 |
| Co-insurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$300 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,590
- Patient pays \$810

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 | \$130 |
| Co-pays | \$600 |
| Co-insurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$810 |

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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.

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